STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

November 14, 2005

Dear Colleague:

The Michigan Department of Community Health (MDCH) is pleased to announce the release of the enclosed Request for Proposal (RFP) for Long-Term Care Single Points of Entry.

Currently, long-term care systems, providers, and care networks are not well integrated throughout Michigan. People in need of long-term care may have no idea of what they need, what is available, or for what they may qualify. Through the creation of long-term care Single Points of Entry pilot sites across the state, the department is confident that outcomes will improve, costs will decrease, and Michigan citizens will be getting the care they desire and need.

Proposals are due by 3 p.m., February 17, 2006 with awards announced by April 17, 2006. Contracts that result from this process will begin on July 1, 2006. There will be a pre-bidder's meeting to be held on December 5, 2005 at 9:00 a.m., at the G. Mennen Williams Building Auditorium (1st Floor), 525 West Ottawa, Lansing, Michigan 48913.

We hope you will take the time to review the enclosed Request for Proposal and submit a proposal. We wish each of you the best.

Sincerely,

Jan Christensen, Interim Director
Office of Long-Term Care
Supports and Services

Paul Reinhart, Director
Medical Services Administration

THIS FORM MUST BE ATTACHED TO THE FRONT OF EACH PROPOSAL

Michigan Department of Community Health
Office of Long Term Care Supports and Services and
Medical Services Administration
Long Term Care Single Points of Entry
Request for Proposals (RFP)

Authority:
Released Pursuant to Governor Granholm's
Executive Order 2005-14

Please type or print clearly in ink:

Date/Time Stamp
When Received:

1. Title of Project:
2. Total Amount of Funding Requested:
3. Name of Applicant Organization: Address:
4. Name of Contact Person: Title: Phone Number:
5. Name of Person to be Notified if Award is Made (If different from #4): Title: Phone Number: Address (If different from #3):
6. Signature: _____ Signature of official signing for applicant agency _____ Name Typewritten or Printed

THIS FORM MUST BE ATTACHED TO THE FRONT OF EACH PROPOSAL

Office of Long-Term Care Supports and Services and Medical Services Administration

Long-Term Care Single Points of Entry Request for Proposals (RFP)

Authority:

Released Pursuant to Governor Granholm's
Executive Order 2005-14

Key Milestone:	**Date:**
Issue Date	November 14, 2005
Pre-Bid Meeting	December 5, 2005
Questions Due	December 2, 2005
Proposal Due Date	February 17, 2006
Award Date	April 17, 2006
Estimated Grant agreement Start Date	July 1, 2006

November 14, 2005

Department of Community Health

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Background and Statement of Work

1.0 PROJECT DESCRIPTION

1.01 PROJECT IDENTIFICATION

This Request for Proposal is identified as the "Long-Term Care Single Points of Entry (SPE) Demonstration Project." This RFP will result in 3 - 4 accepted proposals lasting approximately 27 months.

1.02 BACKGROUND

In response to recommendations included in the Michigan Medicaid Long-Term Care Task Force Final Report (June 2005), the Governor Granholm issued Executive Order 2005-14, which created the Michigan Office of Long-Term Care Supports and Services (OLTCSS). The Office was charged with creating at least three (3) demonstration Long-Term Care Single Points of Entry (SPEs) as a part of a statewide phase-in of the Michigan Medicaid Long-Term Care Task Force Report recommendation for SPEs. Of the demonstration SPEs established, at least one must be in an urban area and one must be in a rural area. Using person-centered planning processes as the model for all activities, regional SPE demonstration agencies will identify available long-term supports and services and assist consumers in accessing the services and programs of their choice through a single regional entity. A long-term care single point of entry is defined as "...a system that enables consumers to access long-term and supportive services through one agency or organization."

Facilitating consumer choice is a key role of an SPE. The Michigan Medicaid Long-Term Care Task Force Report (June 2005) supported the essential role of consumer choice by recommending the following policy changes:

1. Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities.
2. Improve access by establishing *money follows the person* principles that allow individuals to determine, through an informed choice process, where and how their LTC benefits will be used.
3. Designate locally or regionally based "Single Point of Entry" (SPE) agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services.
4. Strengthen the array of LTC services and supports by removing limits on the settings served by MI Choice waiver services and expanding the list of funded services.
5. Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.
6. Promote meaningful consumer participation and education in the LTC system by establishing a LTC Commission and informing the public about the available array of options.
7. Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of long-term care.

8. Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable LTC workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.
9. Adopt financing structures that maximize resources, promote consumer incentives, and decrease fraud.

These recommendations help frame the aims, guiding principles, underlying values and desired approaches to the scope of work for the demonstration SPEs as the LTC consumer point of contact.

1.03 PERSON-CENTERED PLANNING

Person-centered planning (PCP) encompasses the methods by which an individual's personal preferences, desires, and goals are brought to the forefront when the individual needs LTC supports and services. PCP assists the individual to plan for, examine and choose those options that best promote their full participation in living their life in accordance with their preferences and goals. PCP becomes the basis for assisting the individual to choose what will best work for him/her in meeting support and care needs while living and controlling their life in the most integrated setting desired.

The PCP process necessarily requires presence, participation, and direction by the individual. Typically, many aspects beyond professional assessments of the person's care needs and limitations are discussed. The consumer is assisted in the process as he or she desires, by individuals of his/her choice (e.g. family members, friends, caregiver personnel, etc.) selected by the consumer. These chosen individuals support the consumer's expression of personal goals and preferences, help with recognizing and building upon abilities and strengths, and support the personal choice of the types and extent of assistance most supportive of those preferences, goals, abilities and strengths while meeting care and support needs

Plans of supports and services relying on a mix of formal and informal supports, professional and paraprofessional services, and assuring a sufficient response to health and welfare needs are developed only through the use of a PCP process.

The Michigan Medicaid Long-Term Care Task Force Report expressed the importance of assuring availability of independent facilitation for the PCP process, when desired by the individual. An independent facilitation must be conducted by a person who has knowledge and understanding of the PCP process and who can assure that the consumer is maintained as the center of the planning process. Independent facilitation must also assure that the values inherent in person-centered planning are fully implemented. These values include:

A. Every individual possesses strengths and the ability to express preferences and to make choices regardless of cognitive ability and/or other challenges.

B. The individual's choices and preferences shall always be honored and considered, if not always granted.

C. Each individual has gifts and contributions to offer to their family and community, and has the ability to choose how supports, services and/or treatments may help them utilize their gifts and contribute to family and community life.

D. Person-centered planning processes maximize independence, create or maintain community connections, and work toward achieving the individual's dreams, goals and desires.

E. A person's cultural background shall be recognized and valued in the decision-making process.

The Michigan Medicaid Long-Term Care Task Force Final Report further made the following specific recommendations and set the following benchmarks for SPEs:

1.04 FINAL REPORT OF THE MICHIGAN MEDICAID LONG-TERM CARE TASK FORCE (EXCERPT)

Recommendation # 3: Create Single Point of Entry Agencies for Consumers.

Current Issues: Michigan citizens needing long-term care services, for themselves or for loved ones, lack a centralized, neutral source of information and assistance. As they navigate through the maze of programs, they may not find the best mix of services and supports to suit their needs. Many simply are placed in nursing facilities because Medicaid provides funding and because they may not be aware of other options. Consumers also need assistance developing their person-centered plans and coordinating their supports.

Recommended Actions

Create locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of long-term care using person-centered planning process. DCH, or the proposed LTC administration, will oversee the SPE agencies. A SPE is defined as "a system that enables consumers to access long-term and supportive services through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and reassessment." (Source: "Single Entry Point Systems: State Survey Results." Prepared by: Robert Mollica and Jennifer Gillespie, National Academy for State Health Policy).

SPE agencies will provide information, referral, and assistance to individuals seeking LTC services and supports. They will have trained staff and the ability to serve clients who do not speak English. Assistance must include supports coordination and authorizing (but not providing) Medicaid services. They also must serve as a resource on LTC for the community at large, including caregivers. Use of the SPE agency should be mandatory for individuals seeking to access Medicaid funded LTC programs.

Strategies / Action Steps

1. Determine financial eligibility through the appropriate state agency. The process of determining eligibility also helps capture other public and private assistance programs for which the person is eligible. The SPE agencies will provide assistance to consumers in working through the eligibility application process. Single points of entry can facilitate speedier processing and identify barriers to processing. SPE agencies should work with other agencies to resolve barriers found in the system.
2. Make supports coordination a key role of the SPE agencies. Consumers have the ability to change supports coordinators when they feel it is necessary to do so. Individuals should develop their support plans through the person-centered planning process. If the consumer chooses a supports coordinator from outside of the agency, the outside supports coordinator is held to the same restrictions on financial interest and should be held to same standards as SPE supports coordinator. The SPE retains the responsibility of authorizing services.

a. The consumer can choose to have their supports coordinator broker their services or may broker their own services - whichever they prefer.

b. The SPE agency will develop a protocol to inform consumers of their right to change supports coordinators.

c. Establish methodologies to facilitate consumer control of what, by whom, and how supports are provided. Included will be methodologies for consumers to control their budgets or authorizations.

3. Make LTC transition a function of the SPE agencies. This service helps consumers make decisions about their own lives and facilitates a smooth transition between settings as their needs and preferences change.

4. Balance LTC through proactive choice counseling. The goal of proactive choice counseling is to catch people with LTC needs at key decision points (such as hospital discharge) and provide education and outreach to help them understand their options. Involve hospital administrators and social workers in developing protocols for the two systems to work together. This will involve outreach by the SPE to hospitals to explain their functions and benefits. Do outreach to the local physician community as well as other interested parties (Adult Protective Services, police, and others) working in settings where critical decisions are made about long-term care.

5. Mandate use of the SPE agency for individuals who seek to access Medicaid-funded programs. Individuals who are private pay will be able to access all of the services of the SPE agency. The Information and Referral/Assistance functions will be available to everyone at no cost. Private pay individuals may have to pay a fee to access other SPE services (such services may be covered by long-term care or other insurance, however). LTC providers will be required to inform consumers of the availability of the SPE agency.

6. Make a comprehensive assessment, or level of care tool, (developed by the proposed LTC Administration) available from the SPE agencies to determine functional eligibility for publicly funded LTC programs including Home Help, Home Health, Home and Community Based Services waiver (MI Choice), and nursing facilities. SPE agencies will use the Comprehensive Level of Care Tool for all persons coming to the SPE for assessment. The LTC Administration or MDCH is responsible for the development of the comprehensive tool. The SPE is responsible for ensuring the Preadmission Screening and Annual Resident Review (PAS/ARR) screen is done by the responsible agency when appropriate.

7. Require providers of LTC services to offer the Level of Care Determination Tool to private pay consumers. If a provider feels it cannot perform this assessment for the consumer, the provider should avail itself of the SPE agency's ability to perform this function.

8. Locate functional eligibility determination in the SPE agencies as long as there is aggressive state oversight and quality assurance including: 1) SPE agency required procedures to prevent provider bias and promote appropriate services; 2) SPE agency supervision, monitoring, and review of all assessments and support plans/care coordination; 3) state quality assurance monitoring; and 4) consumer advocate and ombudsman monitoring.

9. The SPE agencies cannot be a direct provider of services to eliminate the tendency to recommend its own services to consumers and any other conflicts of interest. (An exceptions process must be developed to address service shortfalls, but in no event shall a SPE be a direct provider of Medicaid services.) The case management currently done by Waiver agents would be provided through SPE agencies under this system. The case management done by Department of Human Services (DHS) for Home Help would be

provided through SPE agencies in this system. SPE agencies will encompass the entire array of Medicaid funded LTC supports.

10. The funding for defined single points of entry is estimated to be between $60 and $72 million statewide. Of this total, approximately $31 to $36 million represents "shifted" dollars from current case management resources, while the remaining amount reflects newly committed dollars needed for this purpose. The annual state share of newly committed dollars upon full implementation (at the end of year 3) will be $15 to $20 million. The Medicaid administrative matching formula should be used as the means of funding the SPE system. The SPE system will be phased-in over a three-year period. The estimate for first year costs for three SPE agencies is $12 to $16 million total funds. The State's GF contribution would be $6 to $8 million of which $3 to $4 million would be cost-shifted. SPEs will be routinely evaluated to ensure the needs of consumers are being met effectively and efficiently. A system wide efficiency gain of 1.7% in LTC expenditures as a result of establishment of single points of entry will fund the entire state system.

11. Develop a standard set of training and certifying criteria for SPE agencies set by the state. By establishing a standard set of certifying criteria, the state will be able to establish quality assurance measures that will provide consistency for consumers and stakeholders. Part of the standard criteria should be a demonstrated knowledge of local and regional resources to supplement Medicaid-funded supports.

12. Standardize the tools used by SPE agencies to allow for portability of benefits for the consumer if they move between regions as well as standardization of data collection for the state.

13. Ensure access to bilingual and culturally competent staff at single points of entry who are trained according to the requirements of the SPE agencies.

14. Implement a quality assurance function focused on the SPE agency that emphasizes, but is not limited to, measures of consumer satisfaction.

15. The state needs to establish a comprehensive oversight system to ensure that all LTC consumers receive those supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible. Quality in this context will be measured by the consumer's satisfaction or lack thereof with the supports as provided.

16. Expand advocacy processes for all LTC consumers. An advocate must be designated and legally granted the duty and authority to advocate on behalf of individual long-term care consumers, since much expertise is required for effective advocacy. The advocacy function also needs to have a systemic approach to advocacy, similar to that performed by the State Long-Term Care Ombudsman or Michigan Protection and Advocacy Services. This more systemic approach would provide greater opportunity for the advocacy group to determine if there are any patterns of policy violations by SPE agencies or for patterns of misunderstandings of the policies by consumers or providers.

17. Develop grievance and appeals processes that empower LTC consumers to challenge any denial of a requested support or any reduction, termination, or suspension of a currently provided support. The grievance process must be available not only for those issues, but also for issues not typically subject to the appeals process (such as the choice of provider).

1.05 SINGLE POINT OF ENTRY SYSTEMS

SPEs are expected to provide information, referral, and assistance to consumers seeking LTC Supports and Services; Long-Term Care Options Counseling for consumers who appear eligible for Medicaid, or others on a private pay basis, utilizing functional eligibility determination, person-centered planning, and benefit counseling activities; and the direct provision of (or ensuring through others) ongoing Supports Coordination for Medicaid long-term care programs as essential functions. SPEs must demonstrate the availability of trained staff experienced in working with the aging population and persons with disabilities. Access to translation services must be available for those who may not speak English or who use alternative methods of communication. Services provided must be culturally competent.

The SPEs are required to serve as the expert resource for long-term care matters for their service regions. Regionally identified SPEs will, after full statewide implementation, serve as the mandatory access point for consumers seeking Medicaid-funded long-term care supports or programs. Initially, during the SPE demonstration phase, a mandatory referral of Medicaid consumers to a SPE prior to admission or enrollment will be required for the designated region. Information and Assistance functions will be available to all requestors as part of agency operations at no cost to the consumer. Consumers who have private funds available may access additional services of the SPE agency through alternate reimbursement mechanisms (e.g. sliding fee scales).

To facilitate prompt implementation of a system of SPEs, this request for proposal is soliciting proposals from those regional entities that can demonstrate the highest degree of collaborative relationships among various public and private stakeholders in the identified geographic area. Proposals that demonstrate a comprehensive and collaborative planning process involving key agencies, organizations, and consumer groups in their designated region will receive higher consideration. Furthermore, proposals that meet all of the specifications of this Request for Proposal (RFP) and include written letters of commitment and support for a specific agency, or a group of agencies, to function as a SPE and that describe the clear role(s) and planned collaborative activities of all involved agencies, will be given the highest consideration.

Although key stakeholders may vary among regions, the following list of potential supporters should be considered in the planning, development and submission of any proposal. *Letters of Commitment (or Intent) and Support must clearly identify the anticipated role or responsibilities of each agency in the formation of an SPE. It is important the letters of support indicate that those signing the letters have had a chance to carefully review a substantial summary work plan of the applicant's proposed application. Highest consideration will be given to those proposals that demonstrate collaborative relationships by letters of commitment or intent from the following types of agencies/organizations within the geographic region.*

A. Required Collaborators for SPE

- Local Department of Human Services
- County Community Mental Health Services Program and/or the Pre-Paid Inpatient Health Plan for Medicaid Specialty Services
- Area Agencies on Aging
- Nursing Facilities – at least 50% in region
- MI Choice Program Agencies
- Hospitals/Health Systems – at least 50% in region

B. Additional Preferred Collaborators for SPE

Since the SPE is expected to collaborate with all relevant stakeholders in a given region, successful proposals will also identify additional collaborative relationships (demonstrated through Letters of Commitment/Intent and Support) from as many or the following types of agencies/organizations as possible:

- Medicaid Service Providers
- Private Service Providers
- Hospice Organizations
- Local Public Health Departments
- Home Health Services Organizations
- Centers for Independent Living
- Local Advocacy Organizations for Aging and Disability Populations
- Local organizations supporting LTC issues (religious, volunteer, fraternal, philanthropic)
- Individual Consumers
- Regional Governing Authority or Authorities (e.g., county boards, multi-county agreements)
- Community Action Agencies
- Housing Authority(ies)
- County-based or Operated Long-term Care Providers
- Multipurpose Collaborative Bodies
- Transportation Authority(ies)
- Dementia Services Agencies, Organizations, Providers
- Traumatic Brain Injury Services Agencies, Organizations, Providers
- Organizations representing specific cultural groups
- Municipalities with populations of more than 100,000 persons
- Others as Appropriate

Local, or regional, agencies, organizations, consumer groups and individuals offering letters of commitment and support for a proposed SPE Agency can do so for more than one proposal.

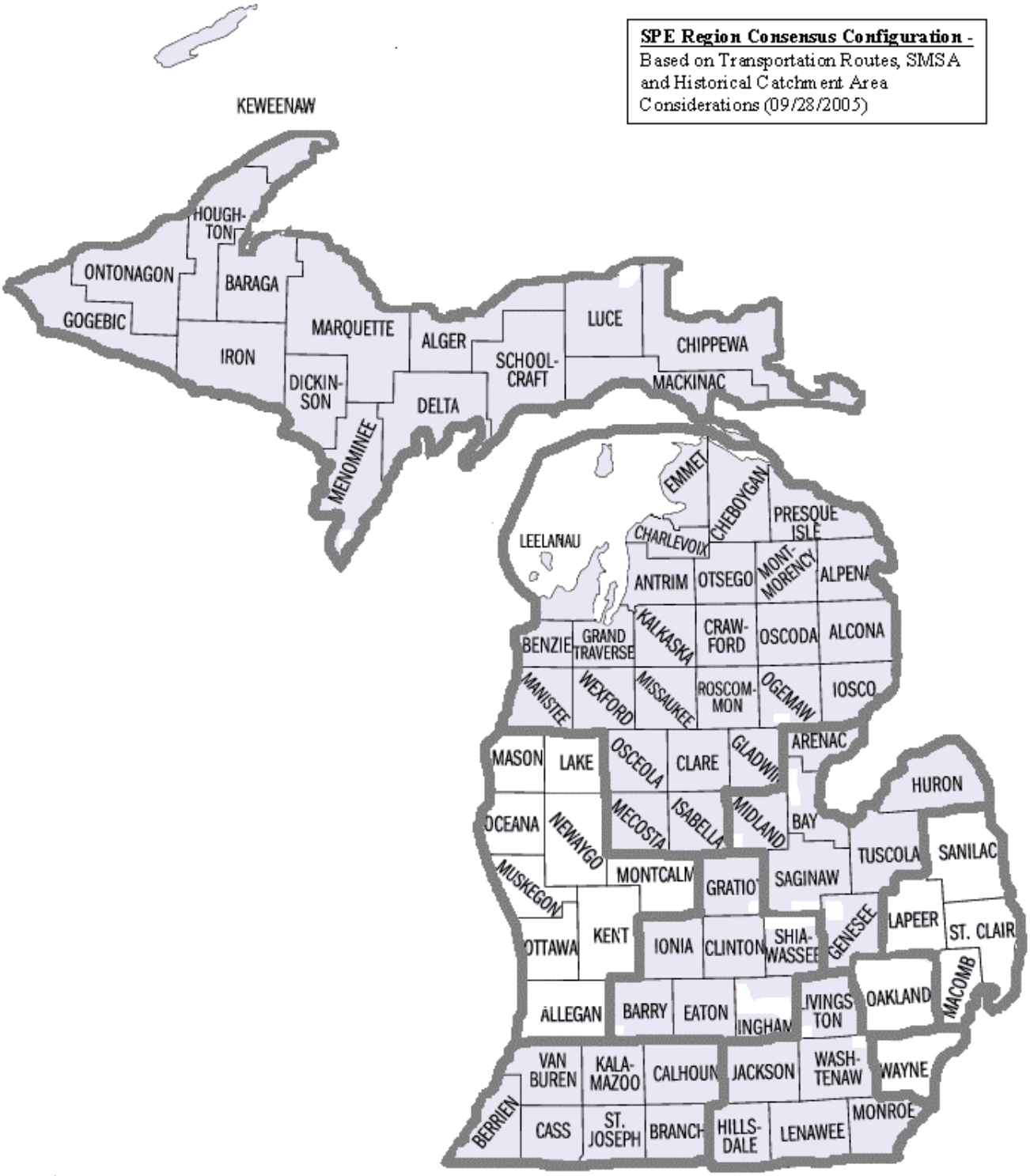
1.06 APPLICANT AGENCIES AND DRAFT PROPOSED SPE REGIONS

Proposals are solicited from single, or jointly-operated governmental and / or not-for-profit entities for the establishment of at least three different SPE demonstration projects throughout the state. Proposals for initial and full implementation of a SPE should meet one and only one of the “draft” proposed geographic areas described in Appendix G. Statistical data related to the regions and the counties (or zip code components where appropriate) in those regions are found within Appendix G.

Appendix G includes information regarding the counties/towns/zip codes that have been designated for each proposed region. Additional background information about specific regions and demographics is also included. Bidders who wish to propose a modification of the demonstration project regions should refer to the information that follows.

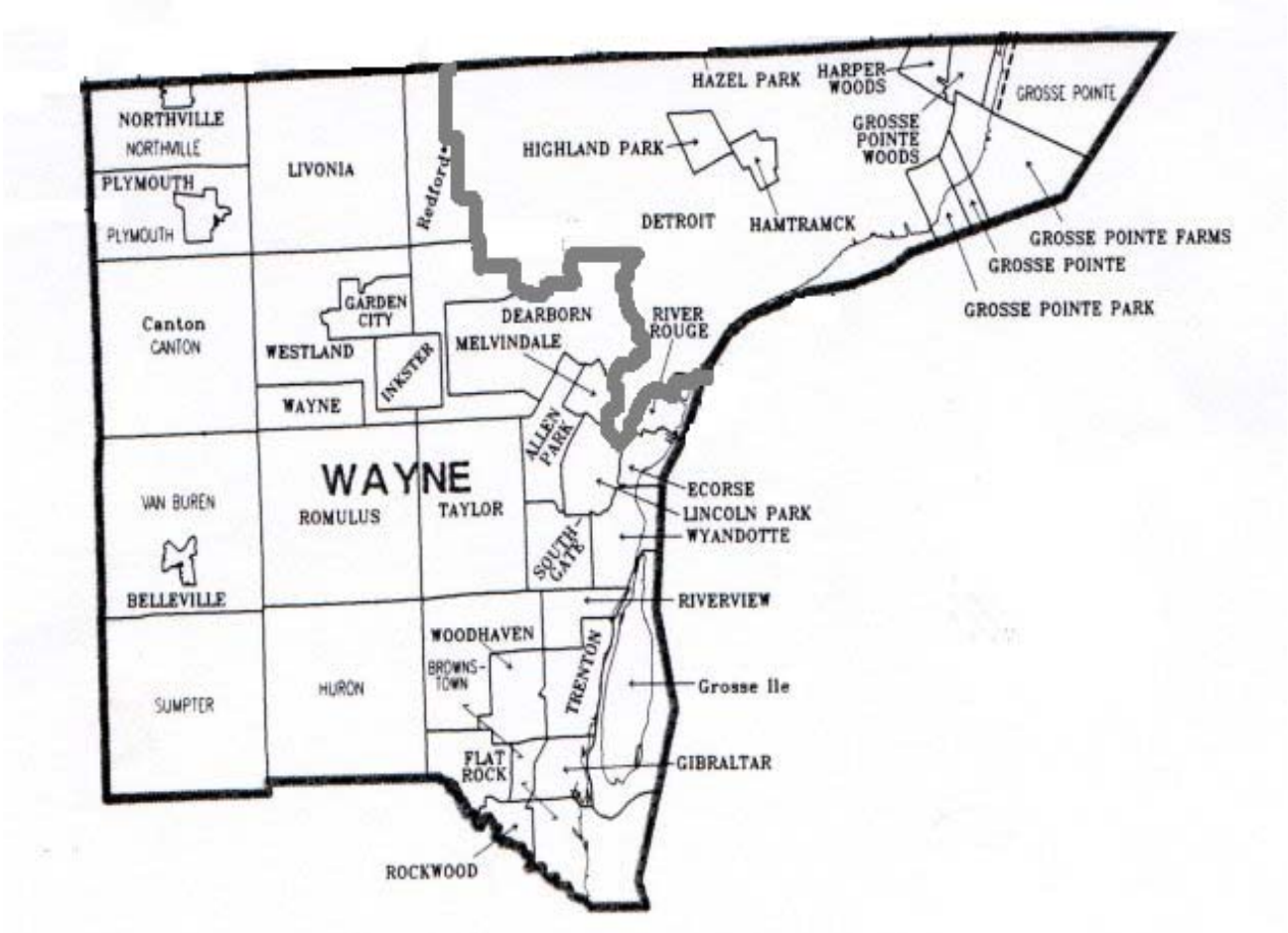
The two maps on the following pages identify the proposed regions. Map 1 includes the Statewide Regional Configuration and Map 2 describes the proposed plan for Wayne County.

Map 1
Proposed Statewide Regional Components



Map 2
Proposed Plan for Wayne County

SPE Region Consensus Configuration (Wayne County Detail)-
Based on Transportation Routes, SMSA and Historical Catchment Area Considerations (09/01/2005)



Rationale for Demonstration Project Regional Boundaries

The proposed regions for the demonstration projects were developed based on the following considerations in order of priority:

1. Economies of scale. It was estimated that a minimum of 50 care manager/supports coordinators would be necessary to justify the administrative costs and structure needed to support them. An efficient organization should not have too many administrative staff or administrative expenses relative to the supports coordinators and intake and referral staff. The estimate of care managers needed per region was derived from the number of Medicaid long-term care consumers in each region with recommended staff / consumer ratios and adjusting the number of care managers based on the current mix of Medicaid long-term care services in the region. An additional consideration was the

number of information and assistance staff that would be needed to serve the total aged population and the Medicaid population with disabilities in the region. Although the minimum of 50 supports coordinators was not achieved in the case of every region, it was maintained for most regions and was a prime consideration in the drawing of proposed boundaries.

2. Standard metropolitan areas. With the exception of the Detroit metropolitan area, no metropolitan area was divided between SPE regions.

3. Historical Medicaid long-term care service catchment areas. Patterns of service delivery that have evolved through the years were considered as well. These included such issues as hospital systems service areas, Area Agency on Aging regions, and Department of Human Services county pairings.

4. Transportation routes and arteries. Accessibility to main and branch SPE offices by individuals will be facilitated by logical transportation groupings. Such routes will also facilitate the travel of supports coordinators to all parts of the region.

Circumstances under which Modifications of Regional Boundaries Will Be Considered

The proposed regions described above will remain somewhat flexible for the duration of this demonstration period. Therefore, proposals may recommend the addition or deletion of a contiguous county (in the case of a non-Wayne County region) or contiguous zip codes (in the case of a Wayne County region). Such proposed modifications must be supported by substantial justification (e.g. existing regional or service relationships, economies of scale, etc.) that supports the addition or deletion of a contiguous area. Additionally, such proposed modifications must reflect how consumers' needs and interests will best be served within the region as a result of the proposed change. In any case, any redrawing of other regions based on this change will have to be consistent with the original decision criteria enumerated above and must facilitate eventual statewide implementation of SPEs. In other words, every area must be included in one SPE region or another. Furthermore, the MDCH reserves the right to make all final decisions regarding the regional configurations that will be acceptable for purposes of this project.

Phase-In Considerations

All proposals are required to address the entire array of Medicaid-funded long-term care supports. Consideration may be given to proposals that describe a plan to fully implement a SPE system for only one part of the SPE region in the first year of the demonstration but must include a plan to phase in all its geographic areas before the end of year 3. The proposal must reflect a plan to include no less than one-third (1/3) of the region's base population at the start of this project. "One-third" shall mean areas that include one-third (1/3) of the SPE region's Medicaid long-term care clients.

Proposals must include written assurances that the bidder is authorized to accept any potential award on behalf of the affected agency(ies) and their governing body(ies) that are expected to provide SPE services to the proposed region. Additionally, the proposal must include written assurances that the bidder is authorized to enter into a grant agreement with the Michigan Department of Community Health to begin implementation of an accepted plan by July 1, 2006. Accepted proposals will be identified by the MDCH by April 17, 2006.

2.0 SCOPE OF WORK, SPE ORGANIZATION, AND CORE FUNCTIONS

2.01 SCOPE

The general scope of work to be undertaken by an SPE is framed in terms of the principles and policy recommendations of the Medicaid Long-Term Care Task Force Report. SPE agencies selected through this RFP are expected to operate in full partnership with the Michigan Office of Long-Term Care Services and Supports (OLTCSS) created by Executive Order 2005-14, and to the extent possible achieve specific SPE Task Force Recommendations and Benchmarks identified under 1.0 PROJECT DESCRIPTION above, and to assist the OLTCSS in the implementation of other related Task Force recommendations.

2.02 SPE ORGANIZATION PLAN

A. Single Point of Entry Agency Consumer Advisory Board (CAB)

Each SPE proposal must include a well-described plan for a SPE Agency Consumer Advisory Board (CAB). Consumer participation in the creation and operation of the SPE is required and proposals must include information on how consumer participation is, or will be, actualized. The Chairperson of the CAB must be a primary consumer. No more than twenty-five percent (25%) of the CAB may represent the direct service provider community. The CAB will provide input to the SPE Governing Board regarding regional issues, adequacy of service capacities, consumer experience, quality management, and other issues relevant to consumer interest.

B. Single Point of Entry Agency Governing Board

An SPE Governing Board, or policy and oversight board is required as part of the organizational and governance plan. The proposed SPE Governing Board is responsible for obtaining, absorbing, applying, and implementing stakeholder recommendations. Consumer input must be utilized by the Governing Board to improve agency policy and operations. The Governing Board must include a significant representation of consumers and must represent the scope and diversity of the community served by the SPE agency. If these criteria are not currently met by the applicant agency, the SPE must submit a plan outlining how the criteria will be met within six (6) months of the award date (4/17/2006). No direct service providers may be included on the SPE Governing Board. Principles of public disclosure, accountability, and transparency must be demonstrated through the SPE's organizational policies and standards.

In addition to direct consumer input, opportunities for broad stakeholder and community input, and their involvement in policy formulation and implementation must be demonstrated throughout the proposal and can occur through existing advisory boards, scheduled community meetings, and public / media events. Proposals must demonstrate how primary consumer input and broader stakeholder and community input impacts SPE decision-making with concrete examples. Preferred proposals will also fully describe how primary consumers assisted in development of the SPE proposal.

C. Agency Approved Title and Communications

The SPE entity will incorporate the phrase "Long-Term Care Single Point of Entry" into its title and all of its publications, agency documents, correspondence, and other identifying communications to clearly present itself as the local/regional single point of entry agency.

All communications of the SPE must be representative of and respond to the language, ethnic, cultural, and communication needs of the region's population.

D. Objective, Conflict Free, One-Stop Customer Service

To prevent situations that create a conflict of interest, or the appearance of a conflict of interest, between the authorization and the provision of services, SPE agencies may not be providers of any services except supports coordination. Agencies that authorize services may not provide those services directly, or have a direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with, an entity that provides hands-on services (except where there is no other viable provider and MDCH approval is granted through a defined exceptions process). Under no circumstances shall an SPE be a direct provider of Medicaid-reimbursed services other than supports coordination.

In instances where a SPE may have a responsibility for Adult Protective Services, the SPE must provide assurances that no conflict of interest exists, or is perceived to exist.

The SPE must develop protocols for identifying and reporting any real or perceived conflict of interest issues on the part of the agency, its partners and its employees. Additionally, the plan must outline how potential conflicts will be addressed.

Notwithstanding the above, applicants submitting a proposal to act as a SPE may receive additional consideration for including a plan that describes how they will co-locate financial and functional eligibility determinations within the proposed SPE agency while ensuring that access to services and providers remains objective and unbiased. These plans must agree to close ongoing monitoring by MDCH to ensure that consumer preferences and choices drive supports and service decisions. MDCH will give preference to those proposals that foster a seamless design of services and activities, and that assure that there are no system barriers to consumer access.

The SPE may also seek and accept funds from public or private foundations and corporations not expressly prohibited by any local, state, or federal statutes. Public disclosure of all sources and amounts of revenue is required.

2.03 CORE FUNCTIONS REQUIRED OF THE SINGLE POINT OF ENTRY

A. Planning and Collaboration

As the designated SPE for a given region, the SPE will function as the convener of the community around the long-term care needs derived from the Regional Community Needs Assessment. The SPE will work with collaborators to determine areas where resources are needed, an analysis of capacity of all provider types and associated quality issues, with recommendations to MDCH that will assist in meeting resource needs and assuring that available long-term care options provide the consumer with choices of service delivery and settings from which he or she can select. Ongoing regional systemic assessment, planning, and evaluation are essential.

The proposed SPE agency should demonstrate the ability to access critical long-term care information and perform effective analysis of the issues identified in the 2005 Long-Term Care Task Force Report, especially as the issues relate to the applicants' proposed region. In addition, within the response to this request for proposal, each proposed SPE agency must submit a Regional Community Needs Assessment that documents the resources and unmet needs of the region. The Assessment and analysis must follow the format that is included in Appendix F (and updated or supplemented as may be requested by MDCH within the initial six months).

The proposal must also include the agency's plan for ongoing annual planning and collaborative activities including annual community re-assessment, regional evaluation, and analyses of

documented improvements and challenges. The updated plan must also address how any identified challenges or barriers will be resolved.

B. Outreach, Education and Advocacy

Outreach Activities

Outreach is a primary function of SPE agencies. SPE Proposals must clearly indicate how they will perform this function. Serving as the gateway to long-term care will necessitate broad recognition among the general public and providers that the SPE exists to assist consumers in planning for and meeting long-term care needs. Additionally, outreach materials and activities must be developed in languages and/or communication formats that meet the needs of the ethnic composition of the people who live within the SPE geographic area. SPE Agencies should use a variety of methods to conduct outreach, including print and media marketing, establishment of linkages with community and faith-based organizations to ensure wide dissemination of information to the general public. SPEs must establish linkages with the providers that represent major pathways to long-term care to ensure consumers are informed of the roles of the SPE, the Consumer Advisory Board and the Governing Board, as well as the various options for long-term care services. Agencies must develop a mechanism to ensure that consumers receive a mandatory referral to an SPE, when indicated.

Public Education

The SPE will be responsible for conducting public education activities, including trainings and dissemination of materials on health, risk, and safety issues of the target population are essential functions of the agency.

Advocacy Activities

The SPE agency must describe a plan to expand advocacy processes for all LTC consumers, and must clearly describe how advocacy functions are incorporated into their agency (using a collaborative process) as they relate to individual consumers and the system as a whole.

C. Information and Assistance

Agencies must provide Information and Assistance to all requestors. SPE agencies will have trained staff and the ability to serve consumers who do not speak English or use alternative methods of communication. Agencies also must serve as a resource on LTC for the community at large, including caregivers. As part of the information and assistance role, agencies will telephonically screen for potential eligibility for LTC programs and services (benefits counseling), and provide education and resource materials about long-term care issues based on individual information needs. When indicated, the agency will refer the consumer for LTC Options Counseling.

D. Person-Centered Planning Processes

Person-Centered Planning process facilitation is a critical SPE function. This is the key process during which a consumer identifies personal life choice issues and is provided the opportunity to make decisions about all his/her long-term care arrangements. This process culminates in the development of a plan of supports and services.

SPE applicants will need to:

- Describe agency knowledge and experience of the principles and values of person-centered planning, and provide a plan for implementation of those practices into all activities.

- Describe the involvement of consumers and consumer advocates as well as other specialists, in their design, implementation, and evaluation of PCP practices and protocols.

- Include, within their quality management plan, assurances of consumer experiences being used as a basis for evolving the PCP practices of the SPE.

- Provide a plan for assuring information, assistance, and training opportunities sufficient for consumers to fully understand and participate in the PCP process.

- Include a method and a timetable for assuring the availability of parties who can provide independent facilitation when requested by the individual consumer.

Applicants must also agree to adhere to statewide MDCH PCP policy and practice guidelines. when developed.

E. Long-Term Care Options Counseling

Eligibility for Medicaid Supports and Services

The SPE will facilitate financial eligibility determinations for Medicaid-funded services and supports in collaboration with the appropriate state agency. The goal for assisting consumers through the application processes and facilitating an eligibility determination is to expedite the process and help capture all other public and private assistance programs for which a person may be eligible. A SPE must work with other agencies to resolve barriers found in the system.

During this process, the consumer undergoes functional eligibility determinations using applicable devices including universal screening and baseline assessment, when developed. This initial assessment identifies basic service needs and potential issues that may benefit from further assessment.

Proactive Choice and Transition Services

LTC facility and other LTC programs, settings, or transition services are required functions of SPE agencies. Transition services will be designed to help consumers make decisions about their own lives, and to facilitate a seamless transition between settings, programs, and services as a consumer's needs and preferences change. Transition services will also be designed to allow for statewide portability of benefits to the extent possible and permitted within current and future regulations, for the consumer, utilizing current eligibility criteria and future MDCH-developed universal assessment tools in the event that a consumer moves from one local/regional area into another, as well as across service systems.

The SPEs are required to promote consumer choice in long-term care by offering thorough proactive choice counseling. The goal of proactive choice counseling is to interact with people who have long-term care needs, especially at key or critical decision making points of their lives (e.g., when dealing with individuals such as hospital discharge staff, law enforcement personnel, protective service workers, etc), and to provide education and outreach that allow them to understand all of their options. The SPE agency must collaborate with hospital administrators, social workers, law enforcement, protective services, and others to develop protocols that permit all systems to work together to address a consumer's immediate and long-term needs.

In addition, the proposal should include specific SPE protocols and processes that ensure that mandatory referrals are provided to each consumer who demonstrates long-term care placement needs at the point of hospital discharge and nursing facility admission.

F. Supports Coordination

Ensuring ongoing Supports Coordination is required as a key function of SPE agencies. Supports Coordinators will authorize and/or ensure service delivery, assist the consumer in obtaining the approved supports and services, ensure that health and safety issues are addressed, and advocate for consumer-directed outcomes. As part of this function, consumers have the ability to change supports coordinators, when desired. If the consumer chooses an independent supports coordinator, the independent supports coordinator is held to the same restrictions on financial conflict and the same performance standards as an agency supports coordinator, including mandatory protection reporting. Independent supports coordinators must be subject to the same review, monitoring, oversight, and training requirements as are agency supports coordinators.

Support plans for consumers must be developed through the person-centered planning process. The consumer may choose to have the supports coordinator broker his/her services or may broker his/her own services - whichever is preferred. Supports coordinators must provide face-to-face contact with consumers at least every three (3) months or more frequently, as needed, when significant changes occur. Re-evaluation using the standardized assessment tool, when available, will be performed as defined within the service plan.

G. Consumer Rights and Responsibilities

The SPE must describe, in its proposal, the proposed protocols for ensuring that consumers understand their rights and responsibilities as well as the methods of making the Rights and Responsibilities information easily accessible.

The SPE must ensure that, at a minimum, the consumer is fully informed of the following consumer rights:

- To access the PCP process and approve the service plan.
- To sign the service plan and receive a copy of the service and care plans.
- To select service providers from among available and qualified providers.
- To access a uniform internal dispute resolution process in the SPE and the right to engage that complaint mechanism for issues that may be appealable or non-appealable.
- To access a uniform appeal process (Medicaid Fair Hearings) when benefits or services are denied or reduced and the issue is appealable.
- To identify and work with the PCP facilitator of their choice.
- To identify and work with the supports coordinator of their choice.
- To enlist the support of the external advocate.

The SPE must ensure that, at minimum, the consumer is fully informed of the following consumer responsibilities:

- To disclose fully and provide true and accurate information to the best of their ability.
- To participate in the development of and to adhere to the agreed-upon plan of care, or to request changes if the plan is not satisfactory.
- To inform supports coordinators if they are unable to keep a scheduled home visit or appointment or to receive scheduled services, or to cancel services arranged on his/her behalf.

- To treat supports coordinators and service providers with the same respect, dignity, and courtesy they expect from them.
- To request further explanation concerning any portion of the care or service plan that they do not understand.
- To actively participate in the development of their plan or decide that they choose not to participate (opt out).

H. Quality Improvement

Quality Management

The SPE agency must describe a plan for a comprehensive quality management system for their agency. Consumers must be involved in the selection and reviewing of quality outcome data (e.g., consumer experience, quality of life, and other outcome indicators). They must also be involved in prioritizing quality management initiatives. For purposes of these demonstration projects, the quality management plan must be based on the CMS Framework for Quality in Home and Community Based Services. (www.cms.hhs.gov/medicaid/waivers/frameworkmatrix.asp.) Measures of consumer-reported experience must be emphasized. SPE activities should be such that the agency is publicly identified as an organization that is committed to and ensures quality in LTC services and supports.

As part of the project, MDCH will work to establish a comprehensive oversight system (based upon the CMS Quality Framework for Home and Community Based Services to ensure that all LTC consumers receive those supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible. Quality in this context will be measured by the consumer's reported experience with the supports as provided, as well as agency performance in meeting standardized utilization, efficiency, and other evidence-based processes and outcomes. A successful comprehensive quality management system will include methods to ensure that the agency's activities, outcomes, and performance will be transparent and accountable to the public.

Specific plans for addressing potential neglect, abuse, and exploitation issues must be included within the quality management plan.

Quality Assurance

Through the demonstration project, MDCH will work with agencies to develop a set of qualifying SPE criteria to set the standards of performance for statewide implementation of SPE model.

Included in the quality management plan should be standard quality assurance processes that ensure consumer access to dispute resolution, grievance and appeal procedures, routine agency operations, and consumer dissatisfaction, as well as a process to review sentinel events and determine necessary systemic interventions.

The SPE must develop, and effectively utilize, grievance and appeals processes that empower LTC consumers to challenge any denial of a requested support or any reduction, termination, or suspension of a currently provided support. The grievance process must be available not only for those issues, but also for issues related to routine agency operations or consumer concerns.

3.0 DELIVERABLES

In addition to meeting the overall guiding principles and service requirements listed above, the SPE agency and their proposal must demonstrate a preparedness to address the specific project requirements described below.

3.01 SPE PROGRAM TRANSITION AND INITIATION

The SPE will provide, or ensure through operating agreements and contracts, the key functions and deliverables listed below. As a part of the proposal work plan, the agency will prepare a transition or initiation plan for these activities and services from current agencies or organizations based on the proposed regional collaboration plan.

SPE Function - Service Outcome Deliverables:

- Planning and Collaboration
- Outreach and Public Education and Advocacy
- Information and Assistance
- Facilitated Person-Centered Planning (with options for independent facilitation)
- Pro-Active Choice and Transition Services
- Long-Term Care Options Counseling
- Ongoing Supports Coordination
- Assure Consumer Rights and Responsibilities
- Quality Management and Improvement

SPE Function - Service Process Deliverables:

- Long-Term Care Medicaid Program Functional/Medical Eligibility Determinations
- Facilitation of Medicaid Financial Eligibility Determination
- Linkages to Medicaid and Other Long-Term Care Services
- Evaluation and Data Reporting
- Electronic Bill Submission

Task A: SPE Initiation and Development

As of the award notice (4/17/2006), the applicant will work to establish agreements for the SPE primary office, satellite offices, telephone lines, staffing, electronic access, formation of Governing and Advisory Authorities, and other business structures and processes necessary to fulfill the functions and services of an SPE. Vendors should be aware that actions related to preparation for performance, before the grant agreement start date (7/1/2006) will not be reimbursed, per section 5.15 incurring costs (page 39). The SPE shall be fully functioning consistent with the applicant's proposal and approved award not later than 7/1/2006. The applicant's SPE proposal must identify the agency organizational structure, collaborators and subcontractor roles, key staff and their resumes, proposed office sites and locations and outline its proposed transition and initiation plan.

Deliverables

- The SPE will submit within 60 days of grant agreement award notice a summary report of office establishment and agency function status as well as a description of community acknowledgement and acceptance.
- The SPE will submit, on a quarterly reporting basis, a description of the current status of activity in establishing and implementing the key functions listed above based upon the agency transition and ongoing operational plan.
- A plan to carry out the Consumer Rights and Responsibilities provision of 2.03, Section G, page 15.
- SPE proposed MDCH policies and procedures for SPE Initiation and Development for statewide SPE Planning, Collaboration, and Rollout are required at least annually.

3.02 PLANNING AND COLLABORATION

Task B: Regional Needs Assessment, Planning, and Coordination

The SPE will convene all relevant stakeholders and the collaborative community around LTC Supports and Services access and resource issues for a given region and work with the collaborative bodies to help resolve any barriers to access, resources, and overall quality as indicated. Within this process, the collaborative bodies will address consumer choice issues and resource/service needs specific to the region.

As part of the work plan, the SPE will submit proposed outcome indicators to measure the success of these tasks.

Deliverables

- Subject to MDCH approval, SPE Policies and Procedures for Community Needs Assessment.
- The SPE must submit an annual report to MDCH updating the regional Long-Term Care Community Needs Assessment submitted with the applicant's original proposal and documenting improvements in access, quality, and resource issues. Included within this report will be MDCH-approved statewide standard data requirements and indicators as they are developed.
- SPE recommendations for state Medicaid policy and operational changes that address, and respond to, consumer proactive choice issues.
- SPE-proposed MDCH policies and procedures for statewide SPE Planning, Collaboration, and Rollout are required at least annually.

3.03 OUTREACH AND PUBLIC EDUCATION

Task C: Outreach and Public Education Plan

The SPE shall develop and implement a plan for an ongoing program of outreach and education to its target populations. As part of the education plan, SPEs must develop a mechanism to ensure that LTC providers are offering the option to access the SPE prior to the provision of any services. The SPE must track the number of referrals offered by provider. The public education plan must include mechanisms for reaching persons who are isolated or otherwise hard to reach, community agencies, and service providers within the SPE region. The goal of the plan is to disseminate information to all those who might be interested in the role of the SPE and the availability of it services. This information should be broadly disseminated to interested parties including families, hospital staff, nursing facilities, local physician community, and others (such as APS workers, law enforcement agencies, human service agencies, etc). The SPE agency must provide materials in languages and formats appropriate to its potential clients.

Task D: Health, Risk, and Safety

As part of the Outreach and Public Education Plan, the SPE will develop and maintain information on risk and safety issues specific to the target populations, for use in public education and other early prevention activities. Education, trainings, and materials should focus on topics of significant interest to the target populations such as caregiver needs and support; abuse, neglect, and exploitation; substance abuse; exercise and activity; nutrition; fall prevention; poly-pharmacy; chronic care issues, etc.

Deliverables

- Subject to MDCH approval, SPE Policies and Procedures for Outreach and Public Education.
- A proposed strategic framework for an Outreach and Public Education Plan must be included within the applicant's proposal work plan and a detailed, updated plan must be submitted to MDCH every six months during the demonstration project. This plan must also include a discussion of methods to be used to address quality issues and to plan for responding to consumer choice of services.
- Quarterly reports based on MDCH-approved outcome indicators for public education and access to information will be required. This information will be used to develop baseline data regarding an effective outreach program against which future performance may be measured.
- An annual report on the adequacy of available materials on risk and safety issues for use in public education, information and assistance, and other early prevention activities. It is expected that agencies will utilize currently developed materials that meet MDCH expectations for quality, readability, and language level whenever possible.
- SPE proposed MDCH policies and procedures for Outreach and Public Education Activities for statewide SPE Planning, Collaboration, and Rollout are required at least annually.

3.04 INFORMATION AND ASSISTANCE ACTIVITIES

Task E: Use and Development of Informational Materials

The SPE will provide long-term care information and assistance to persons from each of the target populations and their representatives and caregivers. The SPE must provide meaningful information using written materials that are reviewed and updated at least annually and are based upon MDCH-approved policies, procedures, and operations. Information must include services, resources, programs, regional or community options that assist persons in making decisions about their long-term care needs. Whenever possible, the SPE should employ those materials that are in use by specific service entities to assure consistency and to avoid duplicative costs. All materials must be identified under the approved agency designated name.

At a minimum, required written materials must address the following:

Adult Protective Services
Planning for long-term care needs
Long-term care insurance
Paying for services
  Universal Screening and Assessment
Medicaid funded Long-term care services:
  Adult Foster Care, Homes for the Aged, nursing facilities, MI Choice Program, Program of All Inclusive Care of the Elderly, Home Health, Home Help
Medicare benefits
  Medicare Part D
Behavioral health
Financial and basic needs
Transportation
Home maintenance
Nutrition and home delivered meals
Employment, training, and vocational rehabilitation
Health care issues for the targeted populations
Counseling
Legal and financial matters
Recreation, life enhancement, and volunteerism
Traumatic Brain Injury
Children Long-term care supports
Consumer rights and due process procedures
Person-centered planning process and options
Adaptive equipment
Advocacy
Caregiver supports

Dementia aging
Respite services Substance Abuse
Basic preventive health care for the

Task F: Information and Assistance Process Development

The SPE must be able to respond to requests for information in a timely manner as described below and to quickly evaluate telephone requests to identify caller issues, determine the level of consumer knowledge, and determine the urgency of the problem. This evaluation shall determine the next steps that must be taken. Referral and assistance counseling at this stage of initial contact may be sufficient to satisfy many consumers' needs.

- Information and Assistance functions must adhere to standards for service delivery as delineated in the Alliance of Information and Referral systems (AIRS) Standards for Professional Information and Referral 4th Edition, October 2002 ***(http://www.airs.org/downloads/NewStandardsforweb10-02.pdf)***

- Information and Assistance coordinators will work to determine the needs of the caller, evaluate resources, indicate the type of organizations that may meet the caller's needs, locate alternative resources, and actively participate in linking the caller to needed services. Information and Assistance coordinators will follow up with consumers as appropriate to determine outcomes and provide additional assistance as needed. The Information and Assistance coordinator must take on an advocacy role on behalf of the consumer when referred services have not been adequately provided.

- When initial information is not sufficient for a consumer to make an informed choice about options and resources, the Information and Assistance coordinator will work with the consumer to help identify and evaluate overall needs and provide further information regarding long-term care services.

- The SPE will provide information and assistance at hours convenient for the public. There must be a toll-free number for easy access. Information and assistance services shall be available for at least 8 continuous hours per day on business days, including mid-day hours and, at minimum, an additional 24 hours per month at times considered most convenient for the public. The SPE must have the capacity to set up appointments after hours to meet public needs as necessary.

- During information and assistance hours, the telephone system must ensure that a caller speaks directly to a person, rather than an answering machine, except in agency emergencies.

- After-hour callers shall receive adequate information to know what to do in case of an emergency or urgent need. Emergency or urgent need is defined as a situation that requires immediate action to ensure health and well being as defined by the consumer. The agency must be able to respond, within two hours, to callers who request assistance after hours. The work plan must include the agency plan for one statewide number for regular office hours, off-hour assistance, and emergencies.

- The SPE must be physically accessible and able to provide information and assistance to walk-in public in a private location.

- A standardized telephone-screening format will be developed as part of the demonstration project.

- When the consumer's long-term care needs appear to be sufficient to qualify for Medicaid-funded programs, and the consumer desires further assistance beyond referral and benefits counseling, the consumer will be scheduled for LTC Options Counseling.

Deliverables

- Subject to MDCH approval, SPE Policies and Procedures for Information and Assistance.

- During the demonstration project, the SPE will further define and refine the information and assistance process as it may evolve to more successfully address consumer needs. An annual report that includes analysis of the defined process and any proposed changes will be required.

- Quarterly reports based on MDCH approved outcome indicators for information and assistance will be required. This information will be used to develop baseline data regarding an effective outreach program against which future performance may be measured.

- SPEs will demonstrate that I & A Specialists have completed the AIRS Certification Program for Information & Referral Specialists and been awarded at least one of the following credentials:

    - AIRS Certified Information and Referral Specialist (CIRS)
    - AIRS Certified Information and Referral Specialist in Aging (CIRS-A)

- SPE proposed MDCH policies and procedures for Information and Assistance for statewide SPE Planning, Collaboration, and Rollout are required at least annually.

3.05 LONG-TERM CARE OPTIONS COUNSELING

Consumers must be provided Long-Term Care Options Counseling when it appears they are or may soon (within six months) be eligible for Medicaid-funded services or they have made a private pay arrangement with the SPE agency. When offers of Long-Term Care Options Counseling and / or screening have been made, the SPE coordinator will:

- Explain the purpose of counseling and assessment and indicate the topics that will be covered.
- Explain how the assessment is conducted, by whom, and professional background of involved staff.
- Convene at a time and place convenient for the consumer, with any persons the consumer may wish to be present.
- Facilitate financial eligibility determinations.

Task F: Proactive Choice of Benefits Counseling

The SPE must develop relationships with all regional hospitals, nursing facilities and community providers to develop and implement an MDCH approved Long-Term Care Options Counseling plan. In accordance with the SPE Outreach and Public Education Plan, the agency will develop processes for sharing information and materials with hospitals, regional nursing facilities, and community agencies to ensure that LTC service population groups are not excluded, and

develop a regional phase-in plan to address every hospital, nursing home and other long-term care agency within the region.

Task G: Functional Eligibility for Medicaid Supports and Services

The SPE shall offer, in any of the following situations, to administer the functional eligibility determination (and Long-term care Options Counseling) for any consumer who belongs to the target populations.

- By request or expression of interest by a consumer
- By a person acting for a consumer
- Referral by hospital
- Referral by nursing facility or other LTC provider
- Determination by SPE that a person might benefit

For persons who need a greater level of assistance than just basic information and basic referral activities, a SPE coordinator will schedule a face-to-face meeting and conduct a functional eligibility determination for long-term care programs. This screening/assessment will occur, whenever possible, at the consumer's place of choice.

Long-Term Care Options Counseling and functional screening must be provided within two (2) business days of the request. If the SPE cannot make contact with the consumer to schedule an assessment after three (3) business days of at least daily attempts, the SPE shall send a letter to the consumer or guardian inviting the consumer to contact them in the future for further counseling or screening. This notification letter must include information encouraging the consumer to contact the agency office.

When adult relatives (that are not guardians) indicate a consumer is not interested in further options counseling or screening, the SPE will send a letter to the direct consumer offering long-term care options counseling or screening.

Counseling must be appropriate to the needs of the consumer for long-term care benefits and services. The SPE must develop processes that include monitoring activity to ensure that there is no agency bias interjected into the consumer's decision-making process.

Based on the findings of the functional eligibility determination, the supports coordinator will, at minimum:

- Provide accurate and current information about the private and public benefits available within the region including the full range of long-term care options available to the consumer. These options may include home care, community services, care management/ coordination, PACE, MI Choice, Adult Home Help, Hospice, Nursing Facility Care, Adult Foster Care, Homes for the Aged, Housing and Nutrition programs.

- Identify potential sources for payment using both private and public funds.

- Present all factors to be considered by the consumer: advantages and disadvantages of consumer programs and benefits in respect to quality, compatibility with chosen lifestyle and residential setting, outcomes of most importance to the consumer, cost, available resources, etc.

- Provide information and technical assistance about accessing benefits.

- Assist potential applicants for Medicaid, social security benefits, nutrition programs, and housing options to locate and gather all necessary documents and information (financial and non-financial) required for their application. Obtain required releases for the protection of confidential information.

- Provide information on consumer rights, complaints, grievances, appeal process, and how to access to the Long-term care External Advocate.

- When indicated, or requested, provide assistance with preparing and filing complaints, grievances, and appeals at local and state levels.

- Make appropriate referrals for employment related counseling and services.

- Coordinate the person-centered planning process with the consumer.

Task H: Person-Centered Planning Process

When the consumer has decided to enroll in any Medicaid-funded long-term care programs, the supports coordinator will utilize the person-centered planning process. Consumers who have arranged to pay privately for services may opt for this service as well. The agency must identify the proposed PCP process that includes the following requirements:

- Support from the consumer to plan and lead their person-centered planning process.
- Choice of person-centered planning facilitator.
- Movement to Supports Coordination.
- A protocol to have the supports coordinator broker services or enable the individual to broker his or her own services.
- A protocol to inform consumers of their right to change supports coordinators or keep their supports coordinator as they transition to other programs.
- Methodologies to facilitate consumer control of what, by whom, and how supports are provided. The processes for ensuring and documenting consumer choice in service providers, specific direct care workers, scheduling of services, and specified outcomes will be developed as part of the demonstration project.
- During the PCP process, the SPE will conduct the PASARR screen for those consumers who voice an interest in nursing facility care.

Deliverables

- Subject to MDCH approval, SPE Policies and Procedures for Long-Term Care Options Counseling.

- During the demonstration project, the SPE will further define and refine the Long-Term Care Options Counseling processes as they evolve to more successfully address consumer needs. An annual report that includes the defined process and any proposed changes will be submitted.

- Quarterly reports based on MDCH-approved outcome indicators for Long-Term Care Options Counseling will be required. This information will be used to develop baseline data regarding an effective Long-Term Care Options Counseling (outreach) program against which future performance may be measured.

- Delivery of a quarterly report describing progress toward consumer involvement, including specific information regarding consumer input.

- Development of person-centered planning methodologies and capacity.

- SPE proposed MDCH policies and procedures for Long-Term Care Options Counseling for statewide SPE Planning, Collaboration, and Rollout are required at least annually.

3.06 ONGOING SUPPORTS COORDINATION

Task I: Ongoing Supports Coordination

Agencies will define and develop processes for ongoing Supports Coordination and/or ensuring Supports Coordination. Agencies must define processes to ensure that supports coordination activities are provided in the most efficient and effective manner, using collaborative agreements or agency staff as indicated.

When the SPE agency provides (or ensures through another entity) supports coordination, the supports coordinator has the following responsibilities to the consumer on an ongoing basis:

- Facilitation of review and update of the person-centered plan.
- Review and evaluation of the quality of care provided to the consumer, based on consumer and program goals.
- Identification of changes in consumer needs that may require further assessments and interventions.
- Assure that ongoing monitoring appropriately identifies consumer needs in regard to satisfaction with services, adjustment to condition, health information and preventive activities, medication issues, rehabilitation, vocational, employment and recreational needs, risk and safety factors, and environmental modifications.
- Identification and resolution of any problems with service delivery.
- Alter service plans to reflect consumer needs.
- Negotiate with service providers over disputes about long-term care services.
- Provide face-to-face contacts every three (3) months, or more frequently if changes occur, for ongoing supports coordination. Reassessment evaluation will include review of the functional eligibility determination, any triggered evaluations, specific evaluation of outcomes based on consumer goals and person-centered plans, and new issues that may have arisen in the interim.
- Financial cost structures for private, non-Medicaid individuals.
- A protocol to have the supports coordinator broker services or enable the individual to broker his or her own services.
- A protocol to inform consumers of their right to change supports coordinators or keep their supports coordinator, if they transition to other programs.
- Methodologies to facilitate consumer control of what, by whom, and how supports are provided. The processes for ensuring and documenting consumer choice in service providers, specific direct care workers, scheduling of services, and specified outcomes will be developed as part of the demonstration project.

Task J: Provide urgent and emergent support when indicated

The SPE will respond to urgent and emergent situations as follows:

- When situations involving an immediate risk arise, the SPE shall make referrals for emergency services. All calls to the SPE requesting immediate assistance will be responded to within 2 hours on a 24 hours per day / 7 days per week basis.

- Appropriate referral to Adult Protective Services when abuse, neglect, or exploitation is suspected. For concerns in licensed settings, agency policies must include the agency notification protocol to relevant licensing officials or regulatory office.

Task K: Program or Service Transitions

The SPE will work with current Medicaid LTC programs and other related programs to transition persons from one service, setting, program to another, when desired. The SPE must assist persons with childhood disabilities experience a seamless transition to adult programs. In addition, the SPE will assume a primary role in hospital, nursing facility and Adult Foster Care / Assisted Living resident transition services. Requirements for these services include:

- Assist all Medicaid nursing facility residents within the region to develop a person-centered plan.
- Assistance to non-Medicaid nursing facility residents may be offered for a fee.
- SPE agencies must utilize the MDCH LTC Facility Transition Practice Guidelines that will be promulgated prior to the SPE implementation date.
- A nursing facility resident outreach plan needs to be developed by each SPE and include how the SPE will inform nursing facility residents of the existence of the agency and the various services it offers, and the right and opportunity to use the agency to coordinate care and services working toward living in the community

Deliverables

- The SPE must include a resident outreach plan as part of the Outreach and Education Plan submitted with the bidder's proposal, which must be updated every six months during the period of the demonstration project.

- During the demonstration project, the SPE will further define and refine the ongoing supports coordination process as it may evolve to more successfully address consumer needs. An annual report that includes the defined process and any proposed changes will be submitted.

- Quarterly reports based on MDCH approved outcome indicators for ongoing supports coordination will be required. This information will be used to develop baseline data regarding an effective outreach program against which future performance may be measured.

- Policies and Procedures for Ongoing Supports Coordination, with MDCH input.

3.07 QUALITY MANAGEMENT

Task L: Development of a Comprehensive Quality Management System

The Quality management plan must be based on the CMS Framework for Quality in Home and Community Based Services (www.cms.hhs.gov/medicaid/waivers/frameworkmatrix.asp) and include the characteristics listed below.

- Measures of consumer experience must be emphasized as the basis for measuring quality.

- Include standard indicators for utilization, efficiency, and outcomes.

- Develop quality indicators that reflect a) consumer priorities for quality of life and individual outcomes; and b) state priorities for health, welfare, and cost effectiveness.

- Consumers must be involved in reviewing quality outcome data (consumer experience, quality of life, and other outcome indicators).

- Description of methods to ensure that all LTC consumers receive supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible.

- A successful comprehensive quality management system will include a description of the methods used to ensure that the agency's activities, outcomes, and performance will be transparent and accountable to the public.

- Included in the quality management plan should be standard quality assurance processes that ensure consumer access to grievance and appeal procedures, routine agency operations and consumer dissatisfaction, as well as process to review sentinel events and determine necessary systemic interventions.

- The SPE shall not knowingly misrepresent or knowingly falsify any information it obtains from, or provides to, any consumer during the course of providing Long-Term Care Options Counseling or screening. The SPE will also reasonably verify the information it receives with the consumers' medical, educational, or other records, as appropriate.

Deliverables

- Subject to MDCH approval, a set of qualifying SPE criteria and policies for a Quality Management System and standards of performance for the SPE agency.

- Specific plans and procedures for effectively addressing potential neglect, abuse, and exploitation issues and annual performance reports.

- SPE proposed MDCH policies and procedures for a Comprehensive Quality Management System for statewide SPE Planning, Collaboration, and Rollout are required at least annually.

4. 0 PROPOSAL REQUIREMENTS AND COMPONENT WEIGHTING

The following outline and weighting should be used to organize the proposal narrative for the scope of work and plan for deliverables as described by this RFP.

I. Background (25 Points)

This section should include a brief but clear discussion of the issues outlined within the Governor's Long-Term Care Task Force Final Report as they relate to the SPE region under consideration, the single point of entry model, and the mandatory referral requirement for the demonstration project. The proposed agency should identify its experience and expertise in long-term care overall, with a discussion of the issues that can be addressed for this region with the proposed SPE demonstration. In addition, the

narrative should include the agency's experience with each of the identified target populations within the region.

The Background Section must also include proposed region information:

- Identification of the proposed region, and whether it should be considered urban or rural with rationale,
- For any proposed changes to the region boundaries, the agency must submit supporting documentation as discussed in Section 1.0.
- Any requests to phase-in geographic areas and rationale.

II. Proposed Organizational Structure and Previous Experience (35 Points)

- Description of proposed organizational structure including the proposed staffing requirements based on the regional analysis;
- Description of key staff;
- Description of the proposed organization of the Consumer Advisory Board and the Governing Board and consumer involvement; how financial and functional eligibility determinations will be located and performed for seamless design; any conflicts of interest, including current provision of LTC services, and methods to eliminate bias;
- Proposed office set up, location, and access;
- Collaborative agreements with key stakeholders, roles, expectations;
- Define any current interagency relationships if the agency itself is a collaboration;
- Written assurances that the proposed agency is an authorized representative for the proposed participating organization(s);
- A description of how principles of public disclosure, accountability to the consumer, and transparency are operationalized through the organization.

The narrative must include information and assurances that demonstrate the proposed agency has no direct provider interests or other conflicts of interest. In addition, the proposed work plan must include information that addresses the following issues:

- Identification of the cultural and ethnic issues of the regional population and agency experience and/or access to language specialists and other experts/assistants in other specific cultural or ethnic matters;
- Specific staff and agency skill in working with the adult with disabilities population with description of common issues and needs of that population;
- Specific staff and agency skill in working with the aging population and persons with long-term care needs with a description of common issues and needs of that population;
- Demonstrated ability to assist and work with persons who have experienced vision or hearing loss, need for adaptive equipment, dementia, or other mental illnesses;
- Demonstrated relationships and description of proposed contracts and relationships with individuals, for-profit entities, or non-profit entities related to long-term care;
- Demonstrated experience in advocating for and protecting consumer rights, the proposed plan for communicating those rights to each consumer, and a monitoring plan to ensure that consumer understanding of their rights and agency or subcontractor adherence to those standards.

III. Scope of Work (100 Points)

Program Transition and Initiation: This section of the proposal should include the following:

- Specific plan for location and establishment of primary office, any plans for satellite offices, telephone access, and electronic system design proposals. Include

information about how the office locations and functions form a seamless functional entity, especially when there are collaborating agencies;
- Transition plan for moving key functions and locating them in this single agency;
- Plan to include ongoing evaluation of community acknowledgement and acceptance of the agency as the region's single point of entry.

Planning and Collaboration: Define the method to review and update the Regional Community Needs Assessment and the review and evaluation process with stakeholders to address ongoing needs and evaluate improvements. Include proposed stakeholders and organizations that would be included in this collaborative analysis and planning. Also include the following topics in this narrative section.

- Summary of the Regional Community Needs Assessment (Appendix F);
- Description of the target populations and how they are represented within the region;
- Definition of the proposed region with analysis of any issues regarding its location. If requesting an alteration to the proposed region, substantial evidence (e.g. existing regional or service relationships, economies of scale) that support inclusion of an additional area as identified under Proposed Region above;
- Methods for convening the collaborative agencies and the community around regional long-term care issues, including resources, access, quality and utilization. A plan to address consumer choice issues and specific regional needs must be included;
- Proposed key indicators for promoting access to programs of consumer choice, quality performance, utilization, service delivery, and consumer experience.

***Outreach and Public Education*:** The applicant should also include here a description of the proposed plan for ongoing Outreach and Public Education for the target populations within the designated region. The proposed plan must include discussion of the following:

- Methods the agency will use to conduct outreach, including print and media marketing, to assist in establishment of the agency as the region's LTC single point of entry;
- Plans for the agency to establish linkages with community and faith-based organizations to ensure wide dissemination of outreach information to the general public. Include information about current relationships with these organizations;
- A description of established linkages with the provider community that represent major pathways to long-term care (to ensure that consumers are informed of the role of the SPE, the Governing and Consumer Advisory Boards, and various provider options for receiving long-term care services);
- The work plan shall include the proposed initial goals for outreach and education based on the needs assessment and possible methods and interventions to meet the goals with planning for ongoing monitoring;
- Mechanisms addressing advocacy needs of the target population in the past and plans to expand advocacy processes for all LTC consumers. These plans must clearly describe how advocacy functions are incorporated into the agency (using a collaborative process) as they relate to both individual consumers and the system as a whole;
- Proposed mechanism for reaching persons who are isolated or hard to reach;
- Agency access to relevant multi-language communication, and planned development of culturally relevant materials;

- Plan for development of outreach materials, acknowledgement that materials must meet the MDCH quality requirements, as well as a proposed plan for reviewing and updating on at least an annual basis;
- Methods for development of informational tools for Health, Risk, and Safety; as well as a discussion of how the agency will meet the reporting requirements for annual review and update of materials based on consumer input and quality.

Information and Assistance: This section should include the proposed processes for information and assistance consistent with the requirements under Appendix F. In addition, the following topics should be included in this narrative.

- Agency experience with AIRS-consistent requirements; if the agency staff are not currently certified under this requirement, submit an evaluation of agency current status and plan to gain these staff certifications;
- Proposed protocols and processes for telephonic screening and transition to LTC Options Counseling – information and assistance coordinator responsibilities;
- Evaluation of the availability of current materials for individual information and assistance, and proposed plans for further material development;
- An evaluation of current usage of telephone screening processes, the agency's success with using them, and known challenges;
- A plan to further define and refine the information and assistance process during the demonstration period.

Long-Term Care Options Counseling: This proposal section should include the proposed processes for LTC Options Counseling consistent with the requirements under Appendices G and H. In addition, the following topics should be included in this narrative.

- Proposed processes for transitioning the consumer from Information and Assistance to Options Counseling – support coordinator responsibilities;
- A discussion and analysis of all potential bias issues especially as related to activities/role conflicts that may affect consumer choice;
- Agency and staff experience and understanding of Medicaid functional eligibility requirements for Medicaid long-term care programs;
- Agency and staff experience with working with consumers to determine options and make decisions;
- Any tools or current process to assist in understanding agency experience with this function or like functions;
- Methods to ensure that the consumer is aware of the process for Medicaid program eligibility determinations, the professional background and persons doing the screening, and appeal rights;
- Specific processes for options counseling, person-centered planning, and functional/ financial screening;
- Single point of entry agencies should include in their proposed work plan a description of the planned process to assist in tool content development and testing for universal screening;
- Agency knowledge and experience with Medicaid functional and financial program eligibility requirements. A description of current tools used to screen for potential Medicaid eligibility and current referral processes. Include in the discussion the specific barriers to efficient and effective eligibility process in the proposed region;
- Proposed agency plan to develop or access person centered planning facilitators, proposed person centered planning process, and protocol for use of external facilitators.

Person-Centered Planning Processes: Identify the agency knowledge and experience with person centered planning processes and any previous staff training plans. Also include the following:

- A description of how person-centered planning has been implemented in the agency, including an analysis of the success of that implementation; include the agency definition for PCP for long-term care, or any other PCP definitions developed for use;
- An implementation plan for embedding PCP, and person centered concepts into agency key functions;
- Current experience of key functional staff with PCP;
- Any current PCP tools in development or in use and associated training materials;
- A description of the involvement of consumers and consumer advocates as well as other specialists in the design, implementation and evaluation of PCP practices and protocols as currently conducted;
- Include assurances of consumer experiences being used as a basis for evolving the person-centered planning practices of the SPE within the Quality Management Plan;
- A plan to develop information, assistance, and training opportunities sufficient for consumers to fully understand and participate in the person centered planning process;
- Methods and a timetable for assuring the availability of parties who can provide independent facilitation when requested by the individual consumer;
- The requirement to adhere to formal policy and practice guidelines, when developed by MDCH, for person-centered planning specifically for long-term care.

Proactive Choice of Benefits Counseling: For Proactive Choice of Benefits Counseling, the agency must describe its experience to date in collaborating and working with area hospitals and nursing facilities, and address any challenges that might be anticipated. Include the following elements:

- The agency plan to implement proactive choice of benefits counseling across the region along with any proposed tools or processes;
- Methods to ensure that target population groups, geographic regions, or specific facilities are not excluded from access to the SPE;
- Methods and issues surrounding the establishment of a mandatory referral requirement by nursing facilities, MI Choice Program agents, Home Help, Home Health, Program of All Inclusive Care of the Elderly (where available), Medicaid Hospice programs, and hospitals should be included in the narrative.

Transition Services: For transition services, the agency should include a description of specific experience with moving persons from hospital, nursing facility, or other residential setting to the community. Any cost or utilization information from transfers, any experienced barriers to transition within the region and methods the agency has used to reduced them, or other regional issues regarding this activity should be included as well as the following:

- Agency and staff experience in coordinating highly complex community care;
- Current and planned access to housing expertise;
- Agency and staff experience with working with persons who need immediate assistance at the point of institutionalization, either hospital, nursing facility, or other residential care to allow informed choice;
- Current plans and relationships with nursing facilities, area hospitals, and community services to work toward consumer-directed outcomes.

Supports coordination: This section must include the proposed process for transition to ongoing supports coordination or a monitoring process for ensuring quality supports coordination. Include the following elements within this section:

- A description of how the agency plans to develop supports coordination expertise for all covered programs;
- Agency and staff experience and expertise in LTC supports coordination;
- Agency and staff experience with working with other agencies to ensure effective and efficient service delivery for persons with complex care and multidisciplinary needs;
- Agency experience in the development of service plans including any current protocols and tools that assist in development of a services plan. Describe methods to ensure that the service plan is consumer directed and evaluated;
- Proposed protocols to ensure consumer choice of the supports coordinator including the process to change supports coordinators;
- Specific processes and agency experience for addressing potential neglect, abuse, and exploitation issues must be included;
- Experience with working across LTC programs to coordinate information and service planning; agency experience and understanding of issues surrounding addressing the health condition and treatment needs of the target populations;
- Development of safeguards to address any potential conflict of interest issues, and methods to ensure informed consumer choice.

Proposals for SPEs should acknowledge the potential duplication of support coordination services between the SPE and some current Medicaid Programs. Successful proposals will describe the collaborative agreements between regional programs and agencies that address this potential duplication and how individual agencies/partners will ensure efficient and effective supports and services coordination.

IV. Quality Management (25 Points)

Within the narrative, include the agency plan to develop a comprehensive quality management system that includes consumer experience as a major outcome indicator. Include information about the following topics:

- The agency experience in developing a systemic quality management plan that focuses on consumer experience as well as process, quality of life, and utilization outcome indicators;
- Agency and staff experience with specific quality management tools;
- The proposed quality management plan for the SPE agency with possible overall process and outcome indicators for measurement of key functions;
- A brief discussion of at least two recent quality improvement initiatives involving the proposed agencies or its partners, the improvement processes itself, and project outcomes;
- Agency experience and knowledge involving the CMS Quality Framework for Home and Community Based Services;
- Experience with and plans for a description of the methods used to ensure that the agency's activities, outcomes, and performance will be transparent and accountable to the public;
- Agency experience with quality assurance processes. Include proposed standard quality assurance processes that ensure consumer access to grievance and appeal procedures, routine agency operations and consumer dissatisfaction, as well as its process to review sentinel events and determine necessary systemic interventions;

- Current methods of, and agency experience with, ensuring that consumers are aware of their rights and due process requirements;
- Description of processes with current consumers regarding rights to appeal, internal grievance and dispute resolution processes;
- A description of the proposed protocol for ensuring consumers understand their rights and due process requirements. Include the methods used in ensuring the Consumer Rights and Responsibilities information is accessible.

V. Reporting Requirements and Demonstration Project Meetings (20 Points)

- Agency's proposed updated annual reporting plan for addressing regional capacity, resources, barriers to care, unmet need, waiting list data, quality issues, and other information that would assist in analyzing LTC access for the region. Such reporting should include the information requested by MDCH in the Regional Community Needs Assessment, Appendix F.

The proposal should include acknowledgement that data collection and evaluation activities must be consistent across all three demonstration projects. The methods and data elements must be based upon the information requested by MDCH in the Regional Community Needs Assessment, Appendix F, and as amended within the first six months following the grant agreement start date.

- A proposed Outreach and Public Education Plan must be included within the narrative, and an updated approved plan must be submitted to MDCH every six months during the demonstration project. This plan will also include a discussion of methods to address quality issues and plan for responding to consumer choice of services;

- Initial transition reports must be submitted within 30 days to identify the status of office establishment and agency function status as well as an indication of community acknowledgement and acceptance;

- Acknowledgement of the need to submit quarterly reports, including proposed data elements when possible, that include the current status in the following:
  - Establishing and implementing the key functions according to the agency transition plan.
  - Establishment and performance of the following key functions, based on MDCH approved outcome indicators. This information will be used to develop baseline data regarding each key function against which future performance may be measured.
    - Planning and Collaboration,
    - Outreach and public education,
    - Information and Assistance,
    - Long-Term Care Options Counseling, including eligibility screening and person centered planning,
    - Supports coordination, whether provided or coordinated.

Include proposed electronic information system structures and requirements, including discussion of capability for electronic bill submission, screening, tracking, and assessment data, as well as outcome data for analysis.

The single point of entry annual report should include in-depth analysis of the following:

- Adequacy of materials on risk and safety issues for use in public education, information and assistance, and other early prevention activities are required. It is expected that agencies will access currently developed materials that meet MDCH expectations for quality, readability, and language level whenever possible.

- Update of the regional Long-Term Care Community Needs Assessment and documenting improvements in access, quality, and resource issues is required. Included within this report may be MDCH-approved standard data requirements and indicators as they are developed. Recommendations for Medicaid policy and operational changes that address, and respond to, consumer proactive choice must be included.

- A discussion of status of work toward definition and refinement of information and assessment process, the LTC options counseling process including person-centered planning, and supports coordination, as these processes may evolve to more successfully address consumer needs. Analysis of the process regarding each function and any proposed changes will be required.

- Agency acknowledgement and willingness to meet with MDCH on a monthly basis, and maintain close contact and availability during the course of the demonstration project.

VI. Budget Justification (20 Points)

Detail all major expenses and costs. Rationale for costs must relate to areas of the Statement of Work and the Workplan. See Appendices A, B, and C.

VII. Workplan (40 Points)

The Workplan template for this RFP is included in Appendix H. The Workplan should be based upon proposed goals for the SPE agency, office establishment, and implementation of key functions. Remember to include:

- Goals and Performance Milestones / Objectives.
- Responsible Parties – Board / Advisory / Staffing Responsibilities.
- Timeframes and Methodology – When and how are thing going to get done.
- Budget Justification and Rationale (supporting all significant projected costs).
- Other significant implementation issues / barriers.

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5.0 ORGANIZATIONAL AND PROCEDURAL STANDARDS

Once the demonstration phase is completed, SPEs will operate based upon a standard set of training and certifying criteria identified by the state. The standard set of certifying criteria established by the state will include quality management activities and quality assurance activities that will provide consistency for consumers and stakeholders. Included in the standard criteria will be a requirement for a demonstrated knowledge by the SPE of all local and regional resources available to supplement Medicaid-funded supports.

5.01 REPORTING AND RECORDS

SPEs will be required to submit the following reports and analysis through the course of the grant agreement:

- Monthly Financial Status Reports (DCH-0384, Appendix D) that document and supports expenses for SPE functions.

- Quarterly reports that address the status of implementing key functional areas and defining policies, processes, and protocols for those functions; specifically Outreach and Public Education, Information and Assistance, LTC Options Counseling, Supports Coordination, and Quality Management and Quality Assurance. Through this process, MDCH will develop required process and outcome indicators. This information will also be used to develop baseline data against which future performance may be measured. The quarterly reports shall describe the work accomplished during the reporting period; planned work to be accomplished during the subsequent reporting period; problems, real or anticipated, which should be brought to the attention of the Grant agreement Administrator; and notification of any significant deviation from previously agreed-upon work plans.

- Semi-annual reporting of the updated Planning and Collaboration Activity Plan that includes regional resource analysis, strategies to address barriers to community based care, and unmet need. The basis for this report will be the Community Regional Needs Assessment as updated.

- Annual reporting that includes an in-depth analysis of agency success in the following areas: promoting consumer choice in long-term care, adequacy of materials for public education and outreach, recommendations for Medicaid policy and operational changes that address consumer choice issues. Included in the annual report should be a discussion of work regarding development of the policies and protocols for the key functions of the SPE: Outreach and Public Education, Information and Assistance, LTC Options Counseling, Supports Coordination, Quality Management and Quality Assurance.

All reports must be provided to MDCH in electronic and hard copy formats unless otherwise specified by MDCH during implementation. The content, frequency, and number of copies for reports will be specified in more detail in the MDCH grant agreement language.

5.02 CONTRACTOR STAFF, ROLES, AND RESPONSIBILITIES

During this demonstration phase, the state reserves the right to approve the qualifications of Applicant's assignment of Key Personnel (specifically including the Executive Director) to this project and to recommend re-assignment of personnel deemed unsatisfactory by the State. It is not acceptable to have untrained, inexperienced, or unproductive staff responsible for SPE supports and services.

The SPE must recruit and hire service and administrative staff who are competent, ethical, qualified, and sufficient in number to implement supports and services. The SPE must strive to have staff members that are representative of the community being served.

SPE Executive Director

The SPE Director must have decision-making authority over the operation of the SPE within a new or existing organization with high-level authority to manage and administer all aspects and functions of the SPE. It is expected that this will be a position dedicated solely to SPE functions. At a minimum, the Director must possess a master's degree in a health or human services field and at least one year of experience working with at least one of the target populations. Alternatively, the Director may possess a bachelor's degree in a health or human services field with at least five years experience working with the target populations.

Information and Assistance Coordinators

Persons in these positions must demonstrate the knowledge of the mission, operations, and referral policies of the SPE. General knowledge of the target populations, expertise in telephone etiquette, excellent communication skills, ability to recognize and address special hearing, language or other communication needs, ability to recognize an emergency, and knowledge of emergency protocols is required.

Persons in these positions assist in the management, implementation, and coordination of the information and assistance aspect of the SPE. Their primary function is to link persons in need, or their advocates, with the appropriate services designed to eliminate or alleviate that need. Information and Assistance Coordinators must demonstrate knowledge of the mission, operations, and referral policies of the SPE.

Information and Assistance Coordinators must possess a bachelors degree preferably in health or human services, and demonstrate at least one (1) year of experience working with at least one (1) of the target populations. MDCH may waive degree requirements in instances where staff has demonstrated experience through other means and the SPE has a plan to ensure that the intake coordinator has received adequate training and demonstrates skills on an ongoing basis. Persons in this role must attend and successfully complete training based on the service standards as required by MDCH.

Within the first year, Information and Assistance Coordinators must have, or obtain certification from the Alliance of Information and Referral Systems as an I&R Specialist

Supports Coordinators

Supports coordinators must demonstrate the ability to solve problems, demonstrate knowledge of long-term care programs and eligibility requirements, recognize opportunities for early intervention, and demonstrate the ability to coordinate complex care. Qualified persons in this position will document common concerns and problems of the target populations and related system-level issues and present that information to appropriate entities for eventual reporting to MDCH. They must also attend and successfully complete training based on the service standards as required by MDCH.

The Supports Coordinator must hold either a bachelor degree in health or human services and at least one (1) year of relevant experience. The MDCH may waive degree requirements in instances where staff has demonstrated commensurate skills with experience through other means, and the SPE has a plan to ensure that the intake coordinator receives adequate training and demonstrates adequate skills on an ongoing basis.

Other Staff

The proposed agency must include, in its RFP, a description of the roles and responsibilities for all staff including supervisory staff, along with their position descriptions.

5.03 STATE STAFF, ROLES, AND RESPONSIBILITIES

The Michigan Office of Long-Term Care Services and Supports and Michigan Medical Services Administration assigned personnel will oversee grantee performance on a day-to-day basis during the term of the grant.

5.04 PROJECT MANAGEMENT

The grantee will carry out this project under the authority of the Michigan Department of Community Health, Office of Long-Term Care Supports and Services (OLTCSS) / MSA grant Administrator. This authority relates to the overall process and acceptable end product and does not imply that the grant administrator will be on-site. The grant administrator will not have direct supervision over the grantee's personnel. The grant administrator will be available for initial consultation and guidance; however, the grantee has the primary responsibility for ensuring compliance with the requirements of this grant.

Although there will be continuous liaison with the grant administrator, the grantee will meet as needed with the grant administrator for the purpose of reviewing progress and providing necessary guidance to the grantee in solving problems, which arise.

Within thirty (30) working days of the award of the grant, the grantee will submit to the MDCH / OLTCSS / MSA grant administrator a revised work plan for final approval.

5.05 RISK MANAGEMENT

The Grantee must create a risk management plan for the program. A risk management plan format will be submitted to the Department for approval within thirty (30) business days after the effective date of the grant award resulting from this RFP. Once both parties have agreed to the format of the plan, it shall become the standard to follow for the duration of the grant.

5.06 CHANGE MANAGEMENT

The following provides the process to follow if a material change in the Applicant's Grant Proposal or the resulting MDCH Grant Agreement is required:

1. A Project Change Report (PCR) shall be the vehicle for communicating change. The PCR, completed by the Grantee's SPE Manager must describe the change; rationale for the change; and, the effect the change will have on the program.

2. The SPE Manager and the MDCH Grant Administrator will review the proposed change. The Grant Administrator shall review it for further consideration or reject it with rationale. If the change is warranted, the Department and the Grantee will sign the PCR, which will constitute approval for the changes. (The timing of the signature by the Department's Grant Administrator will be in accordance with MDCH, the State's Administrative Board or other applicable approval processes.)

A written PCR must be signed by both parties to authorize implementation of the proposed changes and before any changes are made.

5.07 FINAL ACCEPTANCE

Final acceptance will be given upon written approval of the Michigan Department of Community Health and the Grantee.

5.08 FUNDING AND PAYMENT

Proposed funding should be included based on a combination of fixed and variable (per unit basis):

Fixed costs should include Regional Collaborative Activities, Regional Community Needs Assessment, Information and Assistance, Quality Management, Reporting, and electronic data systems.

Per unit costs should be applied to Long-Term Care Options Counseling, Transition services, and Supports Coordination.

Overall proposed costs must be based upon staff/consumer ratios for each long-term care service as identified in the applicant's proposal and as projected in the Medicaid Long-Term Care Task Force Report and Finance Workgroup Reports for SPE costs.

MDCH will reimburse the Grantee an amount not to exceed the amount agreed upon for the performance of all activities necessary or incidental to the performance of work as sent forth in this RFP and in an approved MDCH Grant Agreement. The fees for performance of audits will not be payable until the audits are completed and the required reports has been provided to the grant administrator.

The grantee shall continue to provide all required services pending a revised negotiated rate structure should such a request be received.

The applicant proceeds at its own risk if it takes negotiation, changes, modification, alterations, amendments, clarification, etc., of the specifications, terms, or conditions of the grant agreement from any individual or office other than the grant agreement administrator listed in this RFP.

All communications covering this procurement must be addressed to grant agreement administrator indicated below:

Department of Community Health
Office of Long-Term Care Supports and Services
Attn: Grant Agreement Manager – SPE Project
7th Floor, Capitol View Building
201 Townsend St.
Lansing, MI 48913
(517) 373-2559
All communications should include the subject:
Long-Term Care Single Point of Entry Project

5.09 GRANT TERM

The term of this Grant will be for twenty-seven (27) months and will commence with the issuance of a Grant Agreement. This will be approximately 7/01/2006 through 09/30/2008.

Option. The MDCH reserves the right to exercise an additional one-year option, at the sole option of the MDCH. Grantee performance, quality of products, price, cost savings, and the grantee's ability to deliver on time are some of the criteria that will be used as a basis for any decision by MDCH to exercise an option year.

Extension. At the sole option of the MDCH, the grant may also be extended on a month to month basis. Grantee performance, quality of products, price, cost savings, and the grantee's ability to deliver on time are some of the criteria that will be used as a basis for any decision by MDCH to exercise any extension.

Written notice regarding an optional or month-to-month extension will be provided to the Grantee within 60 days prior to expiration of the term of this grant, provided that the Grantee gives the MDCH a preliminary written notice of its desire to extend the term at least 90 days before the term expires. The preliminary notice does not commit MDCH to an extension. If the MDCH exercises this option, the extended grant shall be considered to include this option clause.

5.10 GOVERNING LAW

The grant shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan. By signing this agreement, grantee consents to personal jurisdiction in the state of Michigan. Any dispute arising herein shall be resolved in the State of Michigan.

5.11 APPLICABLE STATUTES

The following statutes, rules, and laws are applicable to the performance of this grant; some statutes will be reflected in the clauses of the grant agreement. This list is NOT exhaustive.

MI Uniform Commercial Code (MIUCC) MCL 440. (All sections unless otherwise altered by agreement)
MI OSHA MCL §§ 408.1001 – 408.1094
Freedom of Information Act (FIOA) MCL §§ 15.231, et seq.
Health Insurance Portability and Accessibility Act (HIPAA) 45 CFR Part 160 and 164
Natural Resources and Environmental Protection Act MCL §§ 324.101, et seq.
MI Consumer Protection Act MCL §§ 445.901 – 445.922
Laws relating to wages, payments of wages, and fringe benefits on state projects MCL §§ 408.551 – 408.558, 408.471 – 408.490, 1965 PA 390.
Department of Civil Service Rules and regulations
Elliot Larsen Civil Rights Act MCL §§ 37.2201, et seq.
Persons with disabilities Civil Rights Act MCL §§ 37.1101, et seq.
MCL §§ 423.321, et seq.
MCL § 18.1264 (law regarding debarment)
Davis-Bacon Act (DBA) 40 USCU §§ 276(a), et seq.
Contract Work Hours and Safety Standards Act (CWHSAA) 40 USCS § 327, et seq.
Business Opportunity Act for Persons with Disabilities MCL §§ 450.791 – 450.795
Rules and regulations of the Environmental Protection Agency
Internal Revenue Code
Rules and regulations of the Equal Employment Opportunity Commission (EEOC)
The Civil Rights Act of 1964, USCS Chapter 42
Title VII, 42 USCS §§ 2000e et seq.
The Americans with Disabilities Act (ADA), 42 USCS §§ 12101 et seq.
The Age Discrimination in Employment Act of 1967 (ADEA), 29 USCS §§ 621, 623 et seq.
The Old Workers Benefit and Protection Act of 1990 (OWBPA), 29 USCS §§ 626, et seq.
The Family Medical Leave Act of 1993 (FMLA), 29 USC §§ 651 et seq.
The Fair Labor Standards Act (FLSA), 29 USC §§ 201 et seq.
Pollution Prevention Act of 1990 (PPA) 42 U.S.C. §13106
Sherman Act, 15 U.S.C.S. § 1 et seq.
Robinson-Patman Act, 15 U.S.C.S. § 13 et. seq.
Clayton Act, 15 U.S.C.S. § 14 et seq.

5.12 RELATIONSHIP OF THE PARTIES

The relationship between MDCH and the grantee is that of grantor and independent grantee. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The grantee will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of activities under this grant.

5.13 HEADINGS

Captions and headings used in the grant agreement are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this RFP.

5.14 COMPETITION IN SUB-CONTRACTING

The grantee shall select subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the grant agreement.

5.15 ELECTRONIC PAYMENT AVAILABILITY

Electronic transfer of funds is available to State grantees. Grantees are required register with the State of Michigan Office of Financial Management so the State can make payments related to this grant agreement electronically at www.cpexpress.state.mi.us.

5.16 INCURRING COSTS

MDCH is not liable for any cost incurred by the grantee prior to signing of the Grant Agreement. The State fiscal year is October 1st through September 30th. The Contractor(s) should realize that payments in any given fiscal year are contingent upon enactment of legislative appropriations. Total liability of the State is limited to terms and conditions of the Grant Agreement.

5.17 ASSIGNMENT AND DELEGATION

The grantee shall not have the right to assign the grant agreement if issued under this RFP, to assign its rights under a grant agreement, or delegate any of its duties or obligations under the grant agreement to any other party (whether by operation of law or otherwise), without the prior written consent of the MDCH. Any purported assignment in violation of this Section shall be null and void. Further, the grantee may not assign the right to receive money due under the grant agreement without the prior written consent of MDCH.

The grantee shall not delegate any duties or obligations under the grant agreement to a subcontractor other than a subcontractor named and approved in the proposal unless MDCH has given written consent to the delegation.

5.18 PERFORMANCE REVIEWS

MDCH may review with the grantee their performance under the grant agreement. Performance reviews shall be conducted quarterly, semi-annually or annually depending on grantee's past performance with the State. Performance reviews shall include, but not limited to, quality of products/services being delivered and provided, timeliness of delivery, percentage of completion of orders, the amount of back orders, status of such orders, accuracy of billings, customer service, completion and submission of required paperwork, the number of substitutions and the reasons for substitutions, and other requirements of the grant.

5.19 AUDIT OF GRANT AGREEMENT COMPLIANCE/RECORDS AND INSPECTIONS

The grantee agrees that MDCH may, upon 24-hour notice, perform an audit at grantee's location(s) to determine if the grantee is complying with the requirements of the grant

agreement. The grantee agrees to cooperate with the State during the audit and produce all records and documentation that verifies compliance with the grant agreement requirements.

5.20 CERTIFICATIONS AND REPRESENTATIONS

All bidders shall complete this section and submit with their proposal. Failure or refusal to submit any of the information requested in this section may result in the bidder being considered non-responsive and therefore ineligible for award consideration. The State may also pursue debarment vendors that fail or refuse to submit any of the requested information.

In addition, if it is determined that a business purposely or willfully submitted false information, the bidder will not be considered for award, the State will pursue debarment of the vendor, and any resulting grant agreement that was established will be cancelled.

Grantee Information

TAXPAYER IDENTIFICATION NUMBER (TIN)

Vendor Name: _____

( ) TIN: _____

( ) TIN has been applied for

( ) TIN is not required because:

- ( ) Bidder is a nonresident, alien, foreign business that does not have income effectively connected with the conduct of a trade or business in the U.S. and does not have an office or place of business or a fiscal agent in the U.S.
- ( ) Bidder is an agency or instrumentality of a foreign government. If checked, which foreign government _____
- ( ) Bidder is an agency or instrumentality of a federal, state, or local government. If checked, which government _____
- ( ) Other basis: _____

( ) Bidder is not owned or controlled by a common parent as described below. Common Parent means a corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which bidder is a member.

( ) Bidder is owned or controlled by a common parent

( ) Name and TIN of common parent

Name: _____
TIN: _____

News releases

News releases (including promotional literature and commercial advertisements) pertaining to the RFP and grant agreement or project to which it relates shall not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the activities associated with the RFP and grant agreement are to be released without prior written approval of the State and then only to persons designated.

5.21 FREEDOM OF INFORMATION ACT

All information in a bidder's proposal and the grant agreement is subject to the provisions of the Freedom of Information Act. MCL 15.231 *et seq*.

5.22 EX-PARTE COMMUNICATION

A Joint Evaluation Committee (JEC) shall review the proposals received in response to this RFP. The determination regarding which grantee is selected to operate this grant shall be based solely on the information provided by the bidder to the Department of Community Health as required by this RFP. Any communication made between those submitting a proposal and any member of the JEC without the knowledge and consent of the MDCH is considered *ex-parte* communication and is prohibited. If it is determined that there has been *ex-parte* communication or an attempt by a bidder to have *ex-parte* communication, that bidder will be automatically disqualified from consideration of this project.

The prohibition on *ex-parte* communication ensures that the proposal review process remains free from and is not influenced by private, off-the-record communications involving parties interested in the proposal outcome.

Should a bidder be awarded a grant resulting from this RFP, and be found to have failed to abide by the provision set forth in this section, said entity will be in default of the grant agreement. Consequences may include cancellation of the grant agreement.

5.23 PRE-BID MEETINGS AND QUESTIONS

A Pre-Bidder's Meeting will be held on December 5, 2005 at 9:00 a.m., at the G. Mennen Williams Building Auditorium (1st Floor), 525 West Ottawa, Lansing, Michigan 48913.

Questions concerning the specifications contained herein are to be submitted, in writing, no later than 5:00 p.m. on December 2, 2005 to:

Irma Lopez
Capitol View Building, 7th Floor
201 Townsend Street
Lansing, Michigan 48913
lopez@michigan.gov

MDCH will only respond to questions placed in writing and sent to the address above. Answers to questions will be prepared as an addendum and posted on the MDCH website under the corresponding RFP Announcement. The posted addendum officially revises and supercedes the original specifications, terms and conditions. The addendum will be posted approximately December 10, 2005.

5.24 EFFICIENT PROPOSAL

Each proposal should be prepared simply and economically, providing a straightforward, concise description of the bidder's ability to meet the requirements of the RFP. Fancy bindings, colored displays, promotional material, etc., will receive no evaluation credit. Emphasis should be on completeness and clarity of content. Narratives for proposals should be double spaced, 12 point and may not exceed 60 pages not inclusive of appendices, budgets, and letters of support.

5.25 PROPOSAL SUBMISSION

Submit One Original (1) and Seven Copies (7) of your proposal in accordance with the following instructions:

A. PROPOSALS MUST BE RECEIVED AND TIME-STAMPED AT MDCH NOT LATER THAN 3:00 P.M. ON THE DUE DATE SPECIFIED ON THE COVER PAGE OF THIS REQUEST FOR PROPOSAL IN ORDER TO BE CONSIDERED FOR AWARD. NO LATE PROPOSALS WILL BE CONSIDERED.

B. BIDDERS ARE RESPONSIBLE FOR ASSURING THAT ADEQUATE SPE RFP and BIDDER IDENTIFYING INFORMATION APPEARS ON THE OUTSIDE ENVELOPE.

C. The address for proposals submitted by CONTRACT CARRIER, COURIER DELIVERY, or PERSONAL DELIVERY, is:

Department of Community Health
Office of Long-Term Care Services and Supports
7th Floor, Capitol View Building
201 Townsend
Lansing, MI 48913

Proposals submitted through the US. POSTAL SERVICE should be addressed as follows:

Department of Community Health
OLTCSS
7th Floor, Capitol View Building
201 Townsend
Lansing, MI 48913

Bidders are responsible for timely receipt of their proposal at MDCH. This responsibility rests entirely with the bidder, notwithstanding delays resulting from postal handling or for any other reasons. Late proposals will not be accepted or considered except under the following circumstances: a) bids received on time do not meet specifications, or b) no other bids are received.

Be sure to submit with your proposal the Proposal Cover Page included in this Request for Proposal PROPERLY COMPLETED AND SIGNED, AND INSERTED IN YOUR PROPOSAL PACKAGE.

5.26 AWARD AND NEGOTIATIONS

Award Decision

(a) Best Demonstration Project. The award recommendation will be made to the responsive and responsible bidders who offer the best

demonstration project to the MDCH. The best demonstration will be determined by the bidder meeting the highest point threshold and offering the *best combination of planned SPE Core Functions*, as demonstrated by their proposal.

(b) MDCH reserves the right to negotiate with bidders on scope, core functions, and budget prior to the grant award.

5.27 STATE ADMINISTRATIVE BOARD

Bidders are advised that the State Administrative Board, prior to final grant award, must approve all grant agreements / purchase orders of $25,000 or more. The decision of this Board is final.

Funding for these demonstration grant projects remains subject to the availability of funding.

PROGRAM BUDGET SUMMARY

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use WHOLE DOLLARS Only

PROGRAM			**DATE PREPARED**	**Page**	**Of**
CONTRACTOR NAME			**BUDGET PERIOD** From: To:		
MAILING ADDRESS (Number and Street)			**BUDGET AGREEMENT** ☐ ORIGINAL ☐ AMENDMENT ▶	**AMENDMENT #**	
CITY	**STATE**	**ZIP CODE**	**FEDERAL ID NUMBER**		

EXPENDITURE CATEGORY				**TOTAL BUDGET** (Use Whole Dollars)
1. SALARIES & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)				
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES				

SOURCE OF FUNDS

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING				

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385(E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-110

APPENDIX A

PROGRAM BUDGET – COST DETAIL

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page Of

PROGRAM	BUDGET PERIOD From:	To:	DATE PREPARED
CONTRACTOR	**BUDGET AGREEMENT** ☐ ORIGINAL ☐ AMENDMENT		**AMENDMENT #**

1. SALARY & WAGES POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
	1. TOTAL SALARIES & WAGES:		

2. FRINGE BENEFITS (Specify)

☐FICA ☐LIFE INS. ☐DENTAL INS COMPOSITE RATE
☐UNEMPLOY INS. ☐VISION INS. ☐WORK COMP AMOUNT 0.00%
☐RETIREMENT ☐HEARING INS.
☐HOSPITAL INS. ☐OTHER (specify) _____ **2. TOTAL FRINGE BENEFITS:**

3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL:

4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS:

5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Name Address Amount

5. TOTAL CONTRACTUAL:

6. EQUIPMENT (Specify items)

6. TOTAL EQUIPMENT:

7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

7. TOTAL OTHER:

8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) **8. TOTAL DIRECT EXPENDITURES:**

9. INDIRECT COST CALCULATIONS **Rate #1: Base $0 X Rate 0.0000 % Total**
Rate #2: Base $0 X Rate 0.0000 % Total
9. TOTAL INDIRECT EXPENDITURES:

10. TOTAL EXPENDITURES (Sum of lines 8-9)

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0386 (E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-11 Use Additional Sheets as Needed

APPENDIX B

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

I. INTRODUCTION

The budget should reflect all expenditures and funding sources associated with the program, including fees and collections and local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program must equal total funds.

The Program Budget Summary (DCH-0385) is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule (DCH-0386). General instruction for the completion of these forms follows in Sections II-III. Budgets must be submitted on Michigan Department of Community Health approved forms.

II. PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION

Use the **Program Budget Summary (DCH-0385)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.1)** for reference. **The DCH-0386 form should be completed prior to completing the DCH-0385 form.** (Please note: the excel workbook version of the DCH 0385-0386 automatically updates the Program Summary amounts as the user completes the DCH-0386).

A. Program - Enter the title of the program.

B. Date Prepared - Enter the date prepared.

C. Page ___ of ___ - Enter the page number of this page and the total number of pages comprising the complete budget package.

D. Contractor - Enter the name of the Contractor.

E. Budget Period - Enter the inclusive dates of the budget period.

F. Address - Enter the complete address of the Contractor.

G. Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.

H. Federal Identification Number – Enter the Employer Identification Number (EIN), also known as a Federal Tax Identification Number.

I. Expenditure Category Column – All expenditure amounts for the DCH-0385 form should be obtained from the total amounts computed on the Program Budget - Cost Detail Schedule (DCH-0386). (See Section III for explanation of expenditure categories.)

Expenditures:

1. Salaries and Wages
2. Fringe Benefits
3. Travel
4. Supplies and Materials
5. Contractual (Subcontracts)
6. Equipment
7. Other Expenses
8. Total Direct Expenditures
9. Indirect Cost
10. Total Expenditures

J. Source of Funds – Refers to the various source of funds that are used to support the program. Funds used to support the program should be recorded in this section according to the following categories:

11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.
12. State Agreement - Enter the amount of MDCH funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Contractor through the agreement. State percentages are not required.
13. Local - Enter the amount of Contractor funds utilized for support of this program. Local percentages are not required. In-kind and donated services from other agencies/sources should not be included on this line.
14. Federal - Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.

PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION (continued)

15. Other - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.

16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 12 through 15. The total funding amount must be equal to line 10 - Total Expenditures.

K. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or through the Department or some other non-local funding source. Total Budget column represents the program budget amount. **The "K" Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION

Use the **Program Budget-Cost Detail Schedule (DCH-0386)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.2)** for reference.

A. Page ____ of ____ - Enter the page number of this page and the total number of pages comprising the complete budget package.

B. Program - Enter the title of the program.

C. Budget Period - Enter the inclusive dates of the budget period.

D. Date Prepared - Enter the date prepared.

E. Contractor - Enter the name of the contractor.

F. Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

Expenditure Categories:

G. Salaries and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the contractor and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with sub-recipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontract) Expenses.

H. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry could be expressed as a decimal (e.g., Full-time equivalent – FTE) when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.

I. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.

J.Comments - Enter any explanatory information that is necessary for the position description. Include an explanation of the computation of Total Salary in those instances when the computation is not straightforward (i.e., if the employee is limited term and/or does not receive fringe benefits).

K. Salaries and Wages Total - Enter a total in the Position Required column and the Total Salaries and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salaries and Wages expenditure category. If more than one page is required, a subtotal should be entered on the last line of each page. On the last page, enter the total Salaries and Wages amounts.

L. Fringe Benefits – Check applicable fringe benefits for staff working in this program. This category includes the employer's contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the salaries and wage amount.)

M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program**. This includes cost for mileage, per diem, lodging, lease vehicles, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salaries and Wages category) for conducting the program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Travel category (line 3) exceeds 10% of the Total Expenditures (line 10).** Travel of consultants is reported under Other Expenses - Consultant Services.

N. Supplies & Materials - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars ($5,000). This includes office supplies, computers, office furniture, printers, printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Supplies and Materials category (line 4) exceeds 10% of the Total Expenditures (line 10).**

O. Contractual (Subcontracts/Subrecipients) – **Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details **must** include: 1) subcontractor(s) name and address, 2) amount by subcontractor and 3) the total amount for all

subcontractor(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with sub-recipient organizations such as affiliates, cooperating institutions or delegate contractors when compliance with federal grant requirements is delegated (passed-through) to

the sub-recipient contractor. Vendor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.

P. Equipment - Enter a description of the equipment being purchased (including number of units and the unit value), the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. **Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided under line 6. Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement's contract manager.**

Q. Other Expenses - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specifically listed on the Cost Detail Schedule. Other minor items may be identified by general type of cost and summarized as a single line on the Cost Detail Schedule to arrive at a total Other Expenses category. Some of the more significant groups or subcategories of costs are described as follows and should be individually identified in the space provided on and under line 7. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Other Expenses category (line 7) exceeds 10% of the Total Expenditures (line 10).**

1. Communication Costs - Costs of telephone, telegraph, data lines, Internet access, websites, fax, email, etc., when related directly to the operation of the program.
2. Space Costs - Costs of building space, rental and maintenance of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. Department funds may not be used to purchase a building or land.

PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION (continued)

3. Consultant or Vendor Services - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are also to be included in this category.

4. Other - All other items purchased exclusively for the operation of the program and not previously included, patient care, fee for service, auto and building insurance, automobile and building maintenance, membership dues, fees, etc.

R. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.

S. Indirect Cost Calculations - **Enter the allowable indirect costs for the budget.** Indirect costs can only be applied if an approved indirect cost rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department. Attach a current copy of the letter stating the applicable indirect cost rate. **Detail on how the indirect cost was calculated must be shown on the Cost Detail Schedule (DCH-0386)**.

T. Total Expenditures – Enter the sum of item 8 and 9 on line 10.

PROGRAM BUDGET SUMMARY

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM			DATE PREPARED	Page	Of
(A) Budget and Contracts			(B) 7/01/xx	(C) 1	2
CONTRACTOR NAME			BUDGET PERIOD		
(D) Michigan Agency			(E) **From:** 10/01/xx **To:** 9/30/xx		
MAILING ADDRESS (Number and Street)			(G) BUDGET AGREEMENT	AMENDMENT #	
(F) 123 ABC Drive			☐ ORIGINAL ☒ AMENDMENT ▶	1	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER		
Acme	MI	44444	(H) 38-1234567		

(I) EXPENDITURE CATEGORY				(K) TOTAL BUDGET (Use Whole Dollars)
1. SALARIES & WAGES	**43,000**			**43,000**
2. FRINGE BENEFITS	**11,180**			**11,180**
3. TRAVEL	**1,400**			**1,400**
4. SUPPLIES & MATERIALS	**37,000**			**37,000**
5. CONTRACTUAL (Subcontracts/Subrecipients)	**3,500**			**3,500**
6. EQUIPMENT	**5,000**			**5,000**
7. OTHER EXPENSES				
	8,000			**8,000**
9. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	**109,080**			**109,080**
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**109,080**			**109,080**

(J) SOURCE OF FUNDS

11. FEES & COLLECTIONS	**10,000**			**10,000**
12. STATE AGREEMENT	**90,000**			**90,000**
13. LOCAL	**9,080**			**9,080**
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**109,080**			**109,080**

AUTHORITY: P.A. 368 of 1978 **COMPLETION:** Is Voluntary, but is required as a condition of funding	The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385 (E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-11

PROGRAM BUDGET – COST DETAIL

View at 100% or Larger

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use WHOLE DOLLARS ONLY

(B) PROGRAM	(C) BUDGET PERIOD From:	To:	DATE PREPARED
Budget and Contracts	10/01/xx	9/30/xx	7/01/xx
(E) CONTRACTOR Michigan Agency	**(F) BUDGET AGREEMENT** ☒ORIGINAL ☐AMENDMENT		**AMENDMENT #**

(G) 1. SALARY & WAGES POSITION DESCRIPTION	(H) COMMENTS	(I) POSITIONS REQUIRED	(J) TOTAL SALARY
Nurse	9 month position	1	25,000
Project Director		.5	18,000
	(K) 1. TOTAL SALARIES & WAGES:	1.5	$ 43,000

(L) 2. FRINGE BENEFITS (Specify)

☒FICA ☐LIFE INS. ☐DENTAL INS COMPOSITE RATE

☒UNEMPLOY INS. ☐VISION INS. ☒WORK COMP AMOUNT 26%

☐RETIREMENT ☐HEARING INS.

☐HOSPITAL INS. ☐OTHER (specify) _____

2. TOTAL FRINGE BENEFITS: $ 11,180

(M) 3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

Conference registration	$350
Airfare	$600
Hotel accommodations and per diem for 4 days	$450

3. TOTAL TRAVEL: $ 1,400

(N) 4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

Office Supplies	2,000
Medical supplies	35,000

4. TOTAL SUPPLIES & MATERIALS $ 37,000

(O) 5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Name	Address	Amount
ACME Evaluation Services	555 Walnut, Lansing, MI 48933	$ 2,000
Presentations Are Us	333 Kalamazoo, Lansing, MI 48933	$ 1,500

5. TOTAL CONTRACTUAL: $ 3,500

(P) 6. EQUIPMENT (Specify items)

Microscope $5,000

6. TOTAL EQUIPMENT: $ 5,000

(Q) 7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

Communication Costs	$2,400
Space Costs	$3,600
Consultant or Vendor: John Doe, Evaluator, 100 Main, E. Lansing	$2,000

7. TOTAL OTHER: $ 8,000

(R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES: $ 109,080

9. INDIRECT COST CALCULATIONS

Rate #1: Base $0 X Rate 0.0000 % Total $ 0

Rate #2: Base $0 X Rate 0.0000 % Total $ 0

9. TOTAL INDIRECT EXPENDITURES: $ 0

(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9) $ **109,080**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

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DCH-0385 (E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-11

Use Additional Sheets as Needed

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CONTRACT MANAGEMENT SECTION

EQUIPMENT INVENTORY SCHEDULE

Please list equipment items that were purchased during the grant agreement period as specified in the grant agreement budget, Attachment B.2. Provide as much information about each piece as possible, including quantity, item name, item specifications: *make, model,* etc. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Please complete and forward to this form to the MDCH contract manager with the final progress report.

Contractor Name: _____ Contract #: _____ Date: _____

Quantity	Item Name	Item Specification	Tag Number	Purchase Price
1	**LW Scientific M5 Labscope**	• Binocular • Trinocular with C-mount or eye tube • 35mm and digital camera adapters available • Diopter adjustment • Inclined 30 degrees (45 degrees available), rotates 360 degrees • 10X/20 high point eyepieces • Interpupillary distance range 50-75mm	N0938438EW098	$ 5,000
				$
				$
				$
				$
				$
				$
			Total	$ 5,000

Contractor's Signature: _____ Date: _____

FINANCIAL STATUS REPORT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

	Contract Number	Page / Of
Local Agency Name	Program	Code
Street Address	Report Period **Thru** ☐	Date Prepared
City, State, ZIP Code	Agreement Period **Thru**	FE ID Number

Category	Expenditures		Agreement	
	Current Period	**Agreement YTD**	**Budget**	**Balance**
1. Salaries & Wages				
2. Fringe Benefits				
3. Travel				
4. Supplies & Materials				
5. Contractual (Sub-Contracts)				
6. Equipment				
7. Other Expenses				
8. TOTAL DIRECT				
9a.Indirect Costs Rate #1:_%				
9b.Indirect Costs Rate #2:_%				
10. TOTAL EXPENDITURES				
SOURCE OF FUNDS: 11. State Agreement				
12. Local				
13. Federal				
14. Other				
15. Fees & Collections				
16. TOTAL FUNDING				

CERTIFICATION: I certify that I am authorized to sign on behalf of the local agency and that this is an accurate statement of expenditures and collections for the report period. Appropriate documentation is available and will be maintained for the required period to support costs and receipts reported.

Authorized Signature	Date	Title
Contact Person Name		Telephone Number

FOR STATE USE ONLY

	Advance	INDEX	PCA	A OBJ. CODE	AMOUNT
Advance Outstanding					
Advance Issued or Applied					
Balance					

Message

Authority: P.A. 368 of 1978
Completion: is a Condition of Reimbursement

The Department of Community Health is an equal opportunity, employer, services, and programs provider.

DCH-0384(E) (Rev. 4/04) (W) Previous Edition Obsolete

FINANCIAL STATUS REPORT (form DCH-0384)
Form Preparation Instructions
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

I. INTRODUCTION:

This form is available in **MS Excel** (that IS fill-in enabled with calculation formulas) and in **MS Word** (not fill-in enabled).

The Financial Status Report (FSR) (DCH-0384) is used to provide a standardized format for reporting the financial status of individual programs. All expenditures and revenues (including fees, local, state, federal, and others) for the particular program are reported on the FSR. The FSR is typically prepared shortly after the end of each month and must be submitted to the Michigan Department of Community Health, Bureau of Finance, no later than thirty (30) days after the close of the calendar month or other prescribed reporting period, unless otherwise specified in the program agreement. The FSR for the last month in the agreement period (or other prescribed reporting period) is also due thirty (30) days after the end of the agreement. In addition, a final report is required and due as specified in the program agreement. See attachment A of this document for reporting instructions for the final report.

The Financial Status Report is to be prepared reporting expenditures on a cash or accrued basis and revenue on an accrued basis, with the exception of fees which should be reported on a cash basis as received. See following definitions:

Cash Expenditures - Actual cash outlays for goods and services received.

Accrued Expenditures - Goods and services received, but not yet paid for.

Accrued Revenue - Total revenue earned, including amounts received and amounts earned and not received. The amount of accrued revenue must be in compliance with available funding sources per terms of the agreement.

II. DISTRIBUTION:

The original and one (1) copy of the Financial Status Report are prepared and distributed as follows:

Original - MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF FINANCE
ACCOUNTING DIVISION
P.O. BOX 30720
LANSING MI 48909-8220

One Copy - Retained by Local Agency

III. RETENTION:

This report should be retained for a period complying with the retention policies established in the agreement.

IV. FORM PREPARATION:

The Financial Status Report form (Attachment B), an example report (attachment C), and a blank FSR are attached for reference.

A. This space is no longer used.

B. **Local Agency Name** - Enter the name of the local agency.

C. **Street Address** - Enter the street address of the local agency.

D. **City, State, ZIP Code** - Enter the City, State, and ZIP Code of the local agency.

E. **Contract Number** - Enter the Department of Community Health Contract Number.

F. **Program** - Enter the title of the program. (i.e. Governor's Discretionary Fund, Juvenile Intervention, DARE, etc.)

G. **Code** - Enter a program code if applicable.

H. **Report Period** - Enter the inclusive dates covered by the report. (June 1 thru June 30)
Check box if FINAL REPORT.

I. **Date Prepared** - Enter the date on which the report is prepared.

J. **Agreement Period** - Enter the inclusive dates of the agreement.

K. **F.E. ID Number** - Enter Federal Employer Identification Number.

L. **Expenditures Current Period Column** - Enter the current period expenditures for the following items: Expenditures must include only those authorized under the terms of the agreement, as specified in the budget attachment. Report all expenditures related to the Contract, regardless of funding source. (The current period must represent the report period.)

1. **Salaries and Wages -** This category includes the compensation paid to all permanent and part-time employees on the payroll of the local agency and assigned directly to the program. This **does not** include contractual services, professional fees or personnel hired on a private contract basis. It is necessary to maintain sufficient documentation to support the allocation of staff working less than 100% of their time on one program.

2. **Fringe Benefits -** This category is to include the employer's contributions for insurance, retirement, FICA and other similar benefits for all permanent and part-time employees assigned to the program.

3. **Travel -** Use **only** for travel costs of permanent and part-time employees assigned to the program. This includes cost for mileage, per diem, lodging, registration fees and approved seminars or conferences, and other approved travel costs incurred by the employees for the conduct of the program. Travel of consultants is included under Other Expenses - Consultant Services.

4. **Supplies and Materials -** Use for all consumable and short-term items and equipment items costing less than five thousand dollars ($5,000). This includes office, printing, janitorial, postage, and education supplies; medical supplies; contraceptives and vaccines; tape and gauze; educational films, etc., according to the requirements of each applicable program.

5. **Contractual (Sub-Contracts)** – Use for written contracts or agreements with **secondary recipient organizations** such as affiliates, cooperating institutions or delegate agencies. Payments to individuals such as stipends, allowances for trainees and consulting fees are to be identified in the Other Expenses category.

6. **Equipment –** This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, and installation costs and any taxes. Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category. All expenditures for equipment must relate to the budgeted equipment items. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit.

7. **Other Expenses –** This category includes other allowable costs incurred for the benefit of the program. Identify on the available lines the same items identified in the approved Program Budget. Some of the more significant groups or sub-categories of costs follow:

a. **Consultant Services –** These are costs for consultation services related to the planning and operations of the program or for some special aspect of the project. This **does not** include consultant services for patient care, which is covered under item 7.b. Travel and other costs of these consultants are also to be included in this category.
b. **Patient Care –** Services as required such as medical, social and educational services to patients relating to prevention, diagnosis and treatment. This category also includes medical fees, laboratory, pharmacy or other health inpatient care, home care services, treatments, professional and consultation fees and related travel costs, transportation of patients including accompanying parents or guardians (or other escort), and for sundry related support such as meals and housing. This does not include personnel costs which are included under Salaries and Wages.
c. **Rentals and Leases –** Costs of building space, rental of equipment, instruments, etc., necessary for the operation of the program.
d. **Communication Costs –** Cost of telephone, telegraph, data lines, etc., when related directly to the operation of the program.
e. **Other –** All other items purchased exclusively for the operation of the program and not previously included.

8. **Total Direct –** The total of the direct expenditures (lines 1-7).

9a. **Indirect Costs –** Enter the indirect rate #1 and the amount of the indirect costs for the current period. Indirect costs can only be applied if an approved indirect cost rate has been established and is accepted by the Michigan Department of Community Health.

9b. **Indirect Costs –** Enter the indirect rate#2 and the amount of the indirect costs for the current period. Indirect costs can only be applied if an approved indirect cost rate has been established and is accepted by the Michigan Department of Community Health.

10. **Total Expenditures -** Enter the total expenditures being reported for the program. This is the total of lines 8, 9a, and 9b.

11.–14. **Source of Funds -** The various sources of funds utilized to provide program support.

15. **Fees and Collections -** Fees and collections received during the current report period. Fees and collections represent funds, which the program earns through its operation and retains for operational purposes. This would include fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.

16. **Total Funding -** The total funding (lines 12-15) must be equal to the total expenditures (line 10).

M. **Expenditures Agreement YTD Column** - Add the "Current Period" amounts from this period's report and the "Agreement YTD" amounts from the previously submitted period's report for each item (lines 1-16) in the Agreement YTD Column.

Enter only amounts for the current agreement period in this column. **The local agency should assure that no items or unallowable category deviations are reported until approval is requested and received from the Michigan Department of Community Health.**

N. **Agreement Budget Column** - This column needs to reflect the program agreement budgeted amount. Enter the "Agreement Budget" amounts for each item (lines 1-16). (Attachment B of Contract) DO NOT change budget amounts unless a SIGNED amendment has been received.

O. **Agreement Balance Column** - These balances are computed by subtracting the "Agreement YTD" expenditure amount from the "Agreement Budget" amount for each item. Show overages as negative amounts.

P. **Authorized Signature and Date Signed** - This section must be signed by an authorized official, certifying that documentation and records are available and easily accessible in support of all the data contained on the report. The individual signing on behalf of the Local Agency certifies by his/her signature that he/she is authorized to sign on behalf of the Local Agency. Any item found as a result of audits to be improper or undocumented will be subject to an audit citation and generally will require a payment adjustment.

Q. **Title** – Enter the title of the person signing as authorized signature.

R. **Contact Person** - Enter the person's name to whom questions should be directed concerning this report.

S. **Telephone Number** - Enter telephone number of contact person.

T. **FOR STATE USE ONLY** - This section of the form is for State use only.

ATTACHMENT - A

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
FINANCIAL STATUS REPORT (DCH-0384)
FINAL REPORTING

The Financial Status Report for the last month of the agreement period (or other prescribed reporting period) is to be prepared the same as previous monthly reports and is due no later then 30 days from the end of the agreement period. This report is considered a preliminary final FSR.

A final Financial Status Report is due within **sixty days** of the end of the agreement period and must be marked "FINAL". This requires the agency to liquidate all accounts payable and encumbrances within sixty days after the end of the agreement period (see definitions below).

Exceptions may be granted for one-time obligations that cannot be liquidated within this time period. However, should this be the case an additional fifteen days may be provided if a written request for an extension, with the reason why additional time is needed, is submitted by the due date of the final FSR.
Failure to meet these final reporting deadlines may result in the State's inability to reimburse the full amount of the state's share of the gross expenditures.

In addition to submitting FSRs, other financial information will be requested to assist DCH in properly closing the State's fiscal year (September 30). This information will help ensure sufficient funds have been reserved by the state to make reimbursement for the contract in the State's upcoming fiscal year. The additional financial information required will include an estimate of open commitments and obligations incurred as of September 30, but not yet paid. The DCH Accounting Division will provide detailed instructions for reporting additional financial information mid August of each year.

DEFINITIONS:

- **Accounts Payable** - Obligations for goods or services received, which have not been paid for as of the end of the agreement period.

- **Encumbrances** - Commitments at the end of the agreement period related to unperformed (executory) contracts for goods and services.

  Note: If a contract does not end on September 30th it is still necessary to estimate accounts payable as of September 30th.

All inquiries regarding financial reporting issues should be directed to the Expenditure Operations Section of the Accounting Division.

References:
Michigan Department of Management and Budget
- Guide to State Government (1210.27).
- Year-End Closing Guide.

Federal OMB Circular A-102 (Revised & DHHS Common Rule).

ATTACHMENT – B **FINANCIAL STATUS REPORT**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

A	Contract Number E	Page	Of
Local Agency Name B	Program F	Code G	
Street Address C	Report Period H Thru ☐ Final	Date Prepared I	
City, State, ZIP Code D	Agreement Period J Thru	FE ID Number K	

Category	Expenditures		Agreement	
	Current Period	Agreement YTD	Budget	Balance
1. Salaries & Wages	L	M	N	O
2. Fringe Benefits				
3. Travel				
4. Supplies & Materials				
5. Contractual (Sub-Contracts)				
6. Equipment				
7. Other Expenses				
8. TOTAL DIRECT				
9a. Indirect Costs Rate #1:_%				
9b. Indirect Costs Rate #2:_%				
10. TOTAL EXPENDITURES				
SOURCE OF FUNDS: 11. State Agreement				
12. Local				
13. Federal				
14. Other				
15. Fees & Collections				
16. TOTAL FUNDING				

CERTIFICATION: I certify that I am authorized to sign on behalf of the local agency and that this is an accurate statement of expenditures and collections for the report period. Appropriate documentation is available and will be maintained for the required period to support costs and receipts reported.

Authorized Signature P Date	Title Q
Contact Person Name R	Telephone Number S

T **FOR STATE USE ONLY**

	Advance	INDEX	PCA	OBJ. CODE	AMOUNT
Advance Outstanding					
Advance Issued or Applied					
Balance					

Message

ATTACHMENT – C **FINANCIAL STATUS REPORT**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

	Contract Number 20018883	Page 1	Of 1
Local Agency Name *Jones City Police Department*	Program **Truancy Interdiction Program**	Code	
Street Address **110 Temple Street**	Report Period 11/01/00 **Thru** 11/30/00 ☐ **Final**	Date Prepared 12/20/00	
City, State, ZIP Code **Jones City, MI 42321**	Agreement Period 10/01/00 **Thru** 09/31/01	FE ID Number 38-9998888	

Category	Expenditures		Agreement	
	Current Period	Agreement YTD	Budget	Balance
1. Salaries & Wages				
2. Fringe Benefits				
3. Travel				
4. Supplies & Materials	3,189.01	3,689.01	5,000.00	1,310.99
5. Contractual (Sub-Contracts)	17,966.30	19,966.30	38,000.00	18,033.70
6. Equipment				
7. Other Expenses				
8. TOTAL DIRECT	21,155.31	23,655.31	43,000.00	19,344.69
9a. Indirect Costs Rate #1:_%				
9b. Indirect Costs Rate #2:_%				
10. TOTAL EXPENDITURES	21,155.31	23,655.31	43,000.00	19,344.69
SOURCE OF FUNDS: 11. State Agreement	21,155.31	23,655.31	43,000.00	19,344.69
12. Local	0.00	0.00	0.00	0.00
13. Federal	0.00	0.00	0.00	0.00
14. Other	0.00	0.00	0.00	0.00
15. Fees & Collections	0.00	0.00	0.00	0.00
16. TOTAL FUNDING	21,155.31	23,655.31	43,000.00	19,344.69

Completed Example

CERTIFICATION: I certify that I am authorized to sign on behalf of the local agency and that this is an accurate statement of expenditures and collections for the report period. Appropriate documentation is available and will be maintained for the required period to support costs and receipts reported.

Authorized Signature	Date	Title **Chief of Police**
Contact Person Name **Walter Wego**		Telephone Number **(123) 456-7890**

FOR STATE USE ONLY

	Advance	INDEX	PCA	OBJ. CODE	AMOUNT
Advance Outstanding					
Advance Issued or Applied					
Balance					

Message

FINANCIAL STATUS REPORT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

	Contract Number	Page	Of
Local Agency Name	Program	Code	
Street Address	Report Period **Thru** ☐ **Final**	Date Prepared	
City, State, ZIP Code	Agreement Period **Thru**	FE ID Number	

Category	Expenditures		Agreement	
	Current Period	Agreement YTD	Budget	Balance
1. Salaries & Wages				
2. Fringe Benefits				
3. Travel				
4. Supplies & Materials				
5. Contractual (Sub-Contracts)				
6. Equipment				
7. Other Expenses				
8. TOTAL DIRECT				
9a. Indirect Costs Rate #1:_%				
9b. Indirect Costs Rate #2:_%				
10. TOTAL EXPENDITURES				
SOURCE OF FUNDS: 11. State Agreement				
12. Local				
13. Federal				
14. Other				
15. Fees & Collections				
16. TOTAL FUNDING				

CERTIFICATION: I certify that I am authorized to sign on behalf of the local agency and that this is an accurate statement of expenditures and collections for the report period. Appropriate documentation is available and will be maintained for the required period to support costs and receipts reported.

Authorized Signature	Date	Title
Contact Person Name		Telephone Number

FOR STATE USE ONLY

	Advance	INDEX	PCA	OBJ. CODE	AMOUNT
Advance Outstanding					
Advance Issued or					
Balance					

Message

Minimum data and analysis requirements

Region
Discussion of the region, its geography, a brief discussion of its history, rural and urban areas, any specific characteristics that may affect the function of a single point of entry. Most of the data requirements can be met by using the 2000 census data.

Demographic Information
In aggregate and by sector, include the following information:

- Population and population migration trends
- Gender
- Age and age trends using the following age groups: 18-59, 60-64, 65-74, 75-84, 85+, mean and median ages for the region/sectors
- Races and ethnic minorities represented in the region
- Minority population trends
- Any unique cultural or ethnic issues specific to the region
- Marital Status by age group
- Income by age group and marital status
- Persons living in poverty
- General living arrangements
- Disability status by sector
- Educational attainment
- Languages spoken

Health Issues

- Age adjusted all-cause mortality
- Morbidity
- Medically underserved areas
- Hospital access and capacity/#providers and types of hospitals
- Hospital utilization rates
- Chronic disease prevalence
- Number and types of nursing facilities, capacity, occupancy rates, quality issues
- Number of Medicaid proportion, Medicare proportion, dual eligibles
- Health education activity for seniors and adults
- Availability of primary care physicians and availability by specialty
- Physicians by specialty who accept Medicaid
- Senior immunization rates
- Medically underserved areas
- 2000 census information on disability for the region – sensory, physical, mental, self care, and going outside alone.

Nutrition

- Number of nutrition programs and providers

Access to Services
Number (when known), availability (number of agencies, slots, beds, etc) and utilization (when known) of following types of services

- Information and referral, screening
- Adult day care
- Personal care
- Respite
- Senior mobile services
- Assisted living – unlicensed

- Adult Foster Care
- Homes for the aged
- Senior Housing – high rise and low rise
- Section 8 housing – high rise and low rise
- DME providers and access issues
- Number and type of parish nurse programs
- Emergency response systems
- Transportation
- Chore services and snow removal
- Home health agencies
- Private duty agencies
- Home Help
- CMH and services
- Mi choice regions; number of slots, waiting list information

Long Term Care Services and Settings

- Number and type: Hospital affiliated and attached, hospital affiliated, not attached, county medical care facility, Medicaid and Medicare licensure status, for- profit, non-profit, church/ organization affiliated.
- Waiver Agencies
- Nursing Facilities
- Facilities on the CMS watch list, and/or of concern to LTC Ombudsman or similar oversight bodies
- Facilities ranked based on staffing ratio, reported quality indicators required by CMS, survey and certification findings; per diem rates
- Occupancy rates for the region and individually; facility waiting lists
- Any known issues concerning nursing facilities in the region.

Summary and Analysis

A description of the critical resource issues for the region, with specific attention to addressing unmet need, direct workforce issues, rebalancing access.

SPE Region Configuration Proposal (08/24/2005)

Clients Per Care Manager			
Home Help	100	HFA/AFC	140
MI Choice	50	Hospice	1,000
NF	200	MCO/PACE	2,000

Wtd. Avg. Clients Per I&R Spec.	
Per MA LTC Consumers	Per Total Aged & MA Disability Pop.
2,186	36,100

	Unique Clients (Sept 2004)							State Population Counts									
SPE Region	NFs	Hospice	PACE	MIChoice Waiver	Home Help Services	HFA/AFC Home Help Stipend	All LTC Medicaid Clients (A very small number may be in 2 categories)	ABAD Clients	OAA Clients	ABAD & OAA Clients	Mich Pop (2000 Census)	Mich Pop 65 & Over (2000 Census)	I & R Specialists Needed	Care Managers Needed	Medicaid LTC Consumers Per Care Manager	Medicaid LTC Consumers Per I&R Specialist	Total Aged plus Medicaid Disability Population Per I & R Specialist
Flint-Saginaw-Midland-Thumb	2,980	155	-	646	5,105	1,061	9,947	33,446	6,705	40,151	950,825	122,792	4.4	87	114	2,261	35,509
Grand Rapids-Muskegon	3,801	250	-	1,242	4,115	1,512	10,920	34,322	9,407	43,729	1,304,687	147,344	5.0	96	114	2,184	36,333
Macomb-St. Clair	3,183	115	-	318	3,598	425	7,639	19,112	7,502	26,614	1,084,835	143,464	4.0	61	125	1,910	40,644
Mid-Michigan	2,058	84	-	519	2,139	444	5,244	15,137	4,436	19,573	679,973	72,455	2.4	45	117	2,185	36,497
Northern Lower Peninsula	2,878	122	-	673	3,103	759	7,535	19,082	6,245	25,327	640,943	103,885	3.7	65	116	2,036	33,234
Oakland	2,292	95	-	524	3,702	343	6,956	18,016	7,959	25,975	1,194,156	135,394	3.7	62	113	1,880	41,462
Southwest Lower Peninsula	2,879	112	-	1,088	3,154	1,061	8,294	24,540	6,555	31,095	774,617	99,957	3.7	75	111	2,242	33,648
Upper Peninsula	2,376	29	-	436	1,443	451	4,735	8,340	4,499	12,839	317,616	52,489	2.0	38	125	2,368	30,415
Washtenaw-Monroe-Jackson	2,201	82	-	510	2,295	604	5,692	17,120	4,755	21,875	929,630	95,105	2.8	49	116	2,033	40,080
Wayne Northeast	3,528	72	186	732	13,583	772	18,873	66,987	11,965	78,952	1,047,899	114,263	6.8	174	109	2,775	26,654
Wayne West	2,537	99	2	324	3,435	309	6,706	22,076	6,875	28,951	1,028,784	136,585	3.7	56	120	1,812	42,881
Totals and Averages	30,713	1,215	188	7,012	45,672	7,741	92,541	278,178	76,903	355,081		1,223,733	42.2	808	115	2,193	35,590

SPE Region Configuration Proposal (08/24/2005)

County Detail

Clients Per Care Manager				Wtd. Avg. Clients Per I&R Spec.	
Home Help	100	HFA/AFC	140	Per MA LTC	Per Total Aged &
MI Choice	50	Hospice	1,000	Consumers	MA Disability Pop.
NF	200	MCO/PACE	2,000	2,186	36,100

County Code	CountyName	SPE Region	Unique Clients (Sept 2004) NFs	Hospice	PACE	MIChoice Waiver	Home Help Services	HFA/AFC Home Help Stipend	All LTC Medicaid Clients (A very small number may be in 2 categories)	State Population Counts ABAD Clients	OAA Clients	ABAD & OAA Clients	Population (2000 Census)	Population 65 & Over (2000 Census)	I & R Specialists Needed	Care Managers Needed	Medicaid LTC Consumers Per Care Manager	Medicaid LTC Consumers Per I&R Specialist	Total Aged plus Medicaid Disability Population Per I & R Specialist
6	ARENAC	Flint-Saginaw-Midland-Thumb	99	7		16	132	27	281	637	223	860	17,269	2,857	0.1	2.3			
9	BAY	Flint-Saginaw-Midland-Thumb	429	17		122	637	106	1,311	3,271	944	4,215	110,157	16,182	0.6	11.7			
25	GENESEE	Flint-Saginaw-Midland-Thumb	995	37		157	2,522	310	4,021	16,573	2,509	19,082	436,141	50,861	1.9	35.6			
32	HURON	Flint-Saginaw-Midland-Thumb	229	19		42	116	149	555	1,025	431	1,456	36,079	6,996	0.2	4.2			
56	MIDLAND	Flint-Saginaw-Midland-Thumb	237	17		60	407	83	804	1,784	522	2,306	82,874	10,022	0.3	7.1			
73	SAGINAW	Flint-Saginaw-Midland-Thumb	788	51		201	1,108	314	2,462	8,682	1,656	10,338	210,039	28,381	1.1	21.3			
79	TUSCOLA	Flint-Saginaw-Midland-Thumb	203	7		48	183	72	513	1,474	420	1,894	58,266	7,493	0.2	4.3			
			2,980	155	-	646	5,105	1,061	9,947	33,446	6,705	40,151	950,825	122,792	4.4	87	114	2,261	35,509
									1.0%	3.5%				12.9%					
3	ALLEGAN	Grand Rapids-Muskegon	428	6		111	241	67	853	2,054	802	2,856	105,665	11,781	0.4	7.3			
41	KENT	Grand Rapids-Muskegon	1,460	113		381	1,771	624	4,349	15,568	3,947	19,515	574,335	59,795	2.0	37.2			
43	LAKE	Grand Rapids-Muskegon	70	4		31	103	11	219	740	191	931	11,333	2,225	0.1	2.1			
53	MASON	Grand Rapids-Muskegon	133	4		22	90	44	293	820	295	1,115	28,274	4,744	0.1	2.3			
54	MECOSTA	Grand Rapids-Muskegon	132	14		29	185	36	396	1,141	338	1,479	40,553	5,343	0.2	3.4			
59	MONTCALM	Grand Rapids-Muskegon	138	15		46	248	98	545	1,757	451	2,208	61,266	7,449	0.3	4.8			
61	MUSKEGON	Grand Rapids-Muskegon	615	58		383	776	302	2,134	7,039	1,586	8,625	170,200	21,870	0.9	20.7			
62	NEWAYGO	Grand Rapids-Muskegon	196	3		32	276	35	542	1,516	452	1,968	47,874	6,141	0.2	4.6			
64	OCEANA	Grand Rapids-Muskegon	95	3		64	147	55	364	918	251	1,169	26,873	3,763	0.1	3.6			
70	OTTAWA	Grand Rapids-Muskegon	534	30		143	278	240	1,225	2,769	1,094	3,863	238,314	24,233	0.7	10.1			
			3,801	250	-	1,242	4,115	1,512	10,920	34,322	9,407	43,729	1,304,687	147,344	5.0	96	114	2,184	36,333
									0.8%	2.6%				11.3%					
44	LAPEER	Macomb-St. Clair	264	7		23	145	123	562	1,264	469	1,733	87,904	8,465	0.3	4.1			
50	MACOMB	Macomb-St. Clair	2,271	95		190	2,710	82	5,348	12,958	5,611	18,569	788,149	107,995	2.9	42.9			
76	SANILAC	Macomb-St. Clair	214	1		51	197	106	569	1,174	477	1,651	44,547	6,861	0.2	4.8			
74	ST CLAIR	Macomb-St. Clair	434	12		54	546	114	1,160	3,716	945	4,661	164,235	20,143	0.6	9.5			
			3,183	115	-	318	3,598	425	7,639	19,112	7,502	26,614	1,084,835	143,464	4.0	61	125	1,910	40,844
									0.7%	1.8%				13.2%					
8	BARRY	Mid-Michigan	193	11		24	162	64	454	930	394	1,324	56,755	6,708	0.2	3.5			
19	CLINTON	Mid-Michigan	157	5		37	103	19	321	810	264	1,074	64,753	7,058	0.2	2.7			
23	EATON	Mid-Michigan	283	8		74	251	53	669	1,621	567	2,188	103,655	11,818	0.3	5.8			
29	GRATIOT	Mid-Michigan	314	10		25	119	57	525	1,163	508	1,671	42,285	5,731	0.2	3.7			
33	INGHAM	Mid-Michigan	665	30		294	1,133	111	2,233	7,568	1,807	9,375	279,320	26,350	1.0	21.4			
34	IONIA	Mid-Michigan	162	17		27	160	99	465	1,405	378	1,783	61,518	6,175	0.2	3.7			
78	SHIAWASSEE	Mid-Michigan	284	3		38	211	41	577	1,640	518	2,158	71,687	8,615	0.3	4.6			
			2,058	84	-	519	2,139	444	5,244	15,137	4,436	19,573	679,973	72,455	2.4	45	117	2,185	36,497
									0.8%	2.2%				10.7%					
1	ALCONA	Northern Lower Peninsula	73	5		9	46	17	150	342	132	474	11,719	2,856	0.1	1.1			
4	ALPENA	Northern Lower Peninsula	166	16		63	192	32	469	1,189	385	1,574	31,314	5,374	0.2	4.3			
5	ANTRIM	Northern Lower Peninsula	95	2		20	80	43	240	550	207	757	23,110	4,035	0.1	2.0			
10	BENZIE	Northern Lower Peninsula	79			13	70	34	196	426	157	583	15,998	2,817	0.1	1.6			
15	CHARLEVOIX	Northern Lower Peninsula	109	-		22	59	32	222	448	195	643	26,090	3,907	0.1	1.8			
16	CHEBOYGAN	Northern Lower Peninsula	120	12		41	155	34	362	799	299	1,098	26,448	4,758	0.2	3.2			
18	CLARE	Northern Lower Peninsula	124	11		31	152	15	333	1,503	303	1,806	31,252	5,416	0.2	2.9			
20	CRAWFORD	Northern Lower Peninsula	72	1		16	70	10	169	462	137	599	14,273	2,385	0.1	1.5			
24	EMMET	Northern Lower Peninsula	167	4		28	182	43	424	720	389	1,109	31,437	4,519	0.2	3.5			
26	GLADWIN	Northern Lower Peninsula	136	3		21	139	47	346	892	266	1,158	26,023	4,798	0.2	2.8			
28	GRAND TRAVERSE	Northern Lower Peninsula	386	4		70	175	150	785	1,669	611	2,280	77,654	10,216	0.3	6.2			
35	IOSCO	Northern Lower Peninsula	187	7		19	120	12	345	914	334	1,248	27,339	5,906	0.2	2.6			
37	ISABELLA	Northern Lower Peninsula	180	5		27	295	14	521	1,601	337	1,938	63,351	5,755	0.2	4.5			
40	KALKASKA	Northern Lower Peninsula	67	1		35	65	55	223	534	198	732	16,571	2,290	0.1	2.1			
45	LEELANAU	Northern Lower Peninsula	69			6	8	6	89	186	98	284	21,119	3,694	0.1	0.6			
51	MANISTEE	Northern Lower Peninsula	104	5		48	174	22	353	799	264	1,063	24,527	4,437	0.2	3.4			
57	MISSAUKEE	Northern Lower Peninsula	22	3		6	10	2	43	86	37	123	14,478	2,138	-	0.3			
60	MONTMORENCY	Northern Lower Peninsula	65	6		20	60	4	155	380	160	540	10,315	2,469	0.1	1.4			
65	OGEMAW	Northern Lower Peninsula	127	7		21	264	4	423	927	307	1,234	21,645	4,091	0.2	3.7			
67	OSCEOLA	Northern Lower Peninsula	50	2		19	149	29	249	854	177	1,031	23,197	3,297	0.1	2.3			
68	OSCODA	Northern Lower Peninsula	44	1		23	56	3	127	374	127	501	9,418	1,906	0.1	1.3			
69	OTSEGO	Northern Lower Peninsula	92	3		15	142	17	269	607	177	784	23,301	3,227	0.1	2.3			
71	PRESQUE ISLE	Northern Lower Peninsula	83	6		19	54	18	180	372	207	579	14,411	3,220	0.1	1.5			
72	ROSCOMMON	Northern Lower Peninsula	106	2		26	153	24	311	1,024	289	1,313	25,469	6,082	0.2	2.8			
83	WEXFORD	Northern Lower Peninsula	155	16		55	233	92	551	1,424	452	1,876	30,484	4,292	0.2	4.9			
			2,878	122	-	673	3,103	759	7,535	19,082	6,245	25,327	640,943	103,885	3.7	65	116	2,036	33,234
									1.2%	3.0%				16.2%					
63	OAKLAND	Oakland	2,292	95		524	3,702	343	6,956	18,016	7,959	25,975	1,194,156	135,394	3.7	62	113	1,880	41,462

SPE Region Configuration Proposal (08/24/2005)

County Detail

			Unique Clients (Sept 2004)								State Population Counts						Clients Per Care Manager				Wtd. Avg. Clients Per I&R Spec.	
										All LTC Medicaid Clients (A very small number may be in 2 categories)							Home Help	100	HFA/AFC	140	Per MA LTC	Per Total Aged &
																	MI Choice	50	Hospice	1,000	Consumers	MA Disability Pop.
																	NF	200	MCO/PACE	2,000	2,186	38,100
County Code	CountyName	SPE Region	NFs	Hospice	PACE	MIChoice Waiver	Home Help Services	HFA/AFC Home Help Stipend		ABAD Clients	OAA Clients	ABAD & OAA Clients	Population (2000 Census)	Population 65 & Over (2000 Census)		I & R Specialists Needed	Care Managers Needed				
									0.6%	1.5%				11.3%								
11	BERRIEN	Southwest Lower Peninsula	616	23		413	722	274	2,048	6,006	1,600	7,606	162,453	23,437		0.9	20.5					
12	BRANCH	Southwest Lower Peninsula	205	2		43	114	46	410	1,105	384	1,489	45,787	6,021		0.2	3.4					
13	CALHOUN	Southwest Lower Peninsula	562	25		167	545	281	1,580	5,246	1,218	6,464	137,985	18,865		0.7	13.6					
14	CASS	Southwest Lower Peninsula	150	3		93	165	58	469	1,339	420	1,759	51,104	6,923		0.2	4.7					
39	KALAMAZOO	Southwest Lower Peninsula	766	36		154	1,079	202	2,237	6,581	1,571	8,152	238,603	27,234		1.0	19.2					
75	ST JOSEPH	Southwest Lower Peninsula	254	13		45	181	108	601	1,715	531	2,246	62,422	8,105		0.3	4.8					
80	VAN BUREN	Southwest Lower Peninsula	326	10		173	348	92	949	2,548	831	3,379	76,263	9,372		0.4	9.2					
			2,879	112	-	1,088	3,154	1,061	8,294	24,540	6,555	31,095	774,617	99,957		3.7	75		111		2,242	33,648
									1.1%	3.2%				12.9%								
2	ALGER	Upper Peninsula	60			42	18	25	145	220	150	370	9,862	1,694		0.1	1.5					
7	BARAGA	Upper Peninsula	74	3		12	63	35	187	223	140	363	8,746	1,422		0.1	1.5					
17	CHIPPEWA	Upper Peninsula	144	2		18	181	54	399	1,044	312	1,356	38,543	4,889		0.2	3.3					
21	DELTA	Upper Peninsula	257			36	186	65	544	1,125	494	1,619	38,520	6,559		0.2	4.3					
22	DICKINSON	Upper Peninsula	238			60	122	23	443	637	422	1,059	27,472	4,971		0.2	3.8					
27	GOGEBIC	Upper Peninsula	217			24	54	27	322	512	380	892	17,370	3,911		0.1	2.3					
31	HOUGHTON	Upper Peninsula	306	5		88	128	49	576	981	582	1,563	36,016	5,542		0.2	4.9					
36	IRON	Upper Peninsula	215	1		30	88	3	337	401	339	740	13,138	3,290		0.1	2.6					
42	KEWEENAW	Upper Peninsula	28	-		11	15	4	58	61	66	127	2,301	467		-	0.5					
48	LUCE	Upper Peninsula	44	1		7	31	36	119	264	108	372	7,024	1,074		-	0.9					
49	MACKINAC	Upper Peninsula	62	1		3	30	16	112	256	125	381	11,943	2,186		0.1	0.8					
52	MARQUETTE	Upper Peninsula	377	15		69	256	29	746	1,468	700	2,168	64,634	8,755		0.3	6.0					
55	MENOMINEE	Upper Peninsula	177			7	152	43	379	581	357	938	25,326	4,383		0.2	2.9					
66	ONTONAGON	Upper Peninsula	87			4	48	19	158	234	145	379	7,818	1,694		0.1	1.1					
77	SCHOOLCRAFT	Upper Peninsula	90	1		25	71	23	210	333	179	512	8,903	1,652		0.1	1.8					
			2,376	29	-	436	1,443	451	4,735	8,340	4,499	12,839	317,616	52,489		2.0	38		125		2,368	30,415
									1.5%	2.6%				16.5%								
30	HILLSDALE	Washtenaw-Monroe-Jackson	183	9		62	135	97	486	1,339	371	1,710	46,527	6,211		0.2	4.2					
38	JACKSON	Washtenaw-Monroe-Jackson	573	19		161	578	184	1,515	4,503	1,043	5,546	158,422	20,377		0.7	13.2					
46	LENAWEE	Washtenaw-Monroe-Jackson	338	6		74	216	168	802	2,217	638	2,855	98,890	12,554		0.4	6.5					
47	LIVINGSTON	Washtenaw-Monroe-Jackson	276	13		33	205	39	566	1,216	445	1,661	156,951	13,202		0.3	4.4					
58	MONROE	Washtenaw-Monroe-Jackson	309	11		61	323	29	733	2,828	747	3,575	145,945	16,285		0.4	6.2					
81	WASHTENAW	Washtenaw-Monroe-Jackson	522	24		119	838	87	1,590	5,017	1,511	6,528	322,895	26,476		0.8	14.0					
			2,201	82	-	510	2,295	604	5,892	17,120	4,755	21,875	929,630	95,105		2.8	49		116		2,033	40,080
									0.6%	1.8%				10.2%								
82	WAYNE NORTHEAST	Wayne Northeast	3,528	72	186	732	13,583	772	18,873	66,987	11,965	78,952	1,047,899	114,263		6.8	174		109		2,775	26,654
									1.8%	6.4%				10.9%								
82	WAYNE WEST	Wayne West	2,537	99	2	324	3,435	309	6,706	22,076	6,875	28,951	1,028,784	136,585		3.7	56		120		1,812	42,881
									0.7%	2.1%				13.3%								
		Totals and Averages	30,713	1,215	188	7,012	45,672	7,741	92,541	278,178	76,903	355,081	9,953,965	1,223,733		42.2	807		115		2,193	35,590
									0.9%	2.8%				12.3%								

Proposed Single Point-of-Entry Regional Components

8/24/2005

Flint-Saginaw-Midland-Thumb	Grand Rapids-Muskegon	Macomb-St. Clair	Mid-Michigan	Northern Lower Peninsula	Oakland	Southwest Lower Peninsula	Upper Peninsula	Washtenaw-Monroe-Jackson	Wayne Northeast	Wayne West	
Counties	Counties	Counties	Counties	Counties	Counties	Counties	Counties	Counties	Cities/Towns	Zip Codes	Cities/Towns
Arenac	Allegan	Lapeer	Barry	Alcona	Oakland	Berrien	Alger	Hillsdale	Detroit	48101	Allen Park
Bay	Kent	Macomb	Clinton	Alpena		Branch	Baraga	Jackson	Grosse Pointe	48111	Belleville
Genesee	Lake	Sanilac	Eaton	Antrim		Calhoun	Chippewa	Lenawee	Grosse Pointe Farms	48120	Canton
Huron	Mason	St. Clair	Gratiot	Benzie		Cass	Delta	Livingston	Grosse Pointe Park	48122	Dearborn
Midland	Mecosta		Ingham	Charlevoix		Kalamazoo	Dickinson	Monroe	Grosse Pointe Shores	48124	Dearborn Heights
Saginaw	Montcalm		Ionia	Cheboygan		St. Joseph	Gogebic	Washtenaw	Grosse Pointe Woods	48125	Ecorse
Tuscola	Muskegon		Shiawassee	Clare		Van Buren	Houghton		Hamtramck	48126	Flat Rock
	Newaygo			Crawford			Iron		Harper Woods	48127	Garden City
	Oceana			Emmet			Keweenaw		Highland Park	48128	Grosse Ile
	Ottawa			Gladwin			Luce			48134	Inkster
				Grand Traverse			Mackinac		Zip Codes	48135	Lincoln Park
				Iosco			Marquette		48201	48138	Livonia
				Isabella			Menominee		48202	48141	Melvindale
				Kalkaska			Ontonagon		48203	48146	New Boston
				Leelanau			Schoolcraft		48204	48150	Northville
				Manistee					48205	48152	Plymouth
				Missaukee					48206	48154	Redford
				Montmorency					48207	48164	River Rouge
				Ogemaw					48208	48167	Riverview
				Osceola					48209	48170	Rockwood
				Oscoda					48210	48173	Romulus
				Otsego					48211	48174	Southgate
				Presque Isle					48212	48180	Taylor
				Roscommon					48213	48183	Trenton
				Wexford					48214	48184	Waltz
									48215	48185	Wayne
									48216	48186	Westland
									48217	48187	Wyandotte
									48219	48188	
									48221	48192	
									48223	48195	
									48224	48218	
									48225	48229	
									48226	48239	
									48227	48240	
									48228		
									48230		
									48234		
									48235		
									48236		
									48238		

Population Statistics Pertinent to the Proposed SPE Regions

08/24/2005

SPE Region	LTC Medicaid Clients as % of Total Population	Medicaid Disability Population as % of Total Population	All Aged as % of Total Population	All Aged and Medicaid Disability Population as % of Total Population
Flint-Saginaw-Midland-Thumb	1.0%	3.5%	12.9%	16.4%
Grand Rapids-Muskegon	0.8%	2.6%	11.3%	13.9%
Macomb-St. Clair	0.7%	1.8%	13.2%	15.0%
Mid-Michigan	0.8%	2.2%	10.7%	12.9%
Northern Lower Peninsula	1.2%	3.0%	16.2%	19.2%
Oakland	0.6%	1.5%	11.3%	12.8%
Southwest Lower Peninsula	1.1%	3.2%	12.9%	16.1%
Upper Peninsula	1.5%	2.6%	16.5%	19.2%
Washtenaw-Monroe-Jackson	0.6%	1.8%	10.2%	12.1%
Wayne Northeast	1.8%	6.4%	10.9%	19.5%
Wayne West	0.7%	2.1%	13.3%	15.4%
Totals	0.9%	2.8%	12.3%	15.1%

Single Point of Entry Proposed Goals, Objectives, Activities, and Timeline

Goal 1:				
Objective 1.1:				
Action #	**Responsible Party**	**Activity/Task**	**Start Date**	**End Date**
Objective 1.2:				

Single Point of Entry Proposed Goals, Objectives, Activities, and Timeline

Goal 2:				
Objective 2.1:				
Action #	**Responsible Party**	**Activity/Task**	**Start Date**	**End Date**
Objective 2.2:				